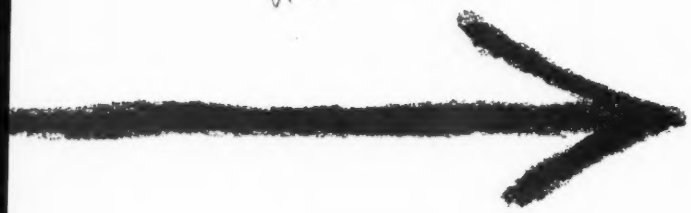
RHODE ISLAND MEDICAL JOURNAL

JANUARY, 1955



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The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XXXVIII, No. 1 January, 1955

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PLASTIC PLANING OF POST-ACNE SCARS

MALCOLM A. WINKLER, M.D.

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POST-ACNE SCARRING and other facial blemishes may profoundly affect the psyche and emotional state of an individual. Far-reaching social and economic disruptions may be the aftermath. The embitterments, frustrations and depressions of those scarred particularly at a critical age are inconceivable to those not similarly afflicted. The facial disfigurements are obvious, but the psychic trauma expressed in an altered and indirect manner is not always apparent to cursory observation.

Any method advanced to remove or render less conspicuous these integumental imperfections warrants consideration. Many procedures have been introduced through the years but dispassionate group appraisal revealed disappointment to physicians and patients alike. More recently, the sandpaper technique of Iverson[1] and later the Kurtin[2] method of plastic planing with revolving steel brushes have given excellent results. I believe the Kurtin method the procedure of choice. Before discussing this procedure, the writer's experience over the last sixteen years will be reviewed.

Results of recommended blistering doses of ultra-violet[3] have been capricious and transitory for scars of long duration but invaluable for diminishing or aborting incipient scars of active acne.

Exfoliation with resorcin or phenol compounds[4] or trichloroacetic acid has produced marked reactions but on subsidence the scars usually remain untouched. Dexterity of technique and sacrifices of the patient have usually gone unrewarded.

The application of CO_2 slush[5] temporarily enjoyed some popularity but proved disappointing after many painstaking trials.

Wallace Marshall[6] reported partial scar absorption with refined experimental liver extract but personal experience with many different liver extracts was without effect in acne or post-acne scars.

Scarification[7] with a fine needle or scalpel in crisscross fashion after anesthesia with 1% Procaine HCL has been recommended by Gilges, etc. This method is tedious, laborious and lacks the fine control of the Kurtin method.

Employment of monopolar spark gap electrodesiccation[8] to produce destruction of tissue around scar and by so doing produce apparent flattening has afforded improvement in selected cases but newer methods are far superior.

Gratifying and encouraging results have followed fulguration but the patients have been rebellious and unsympathetic to the numerous novocaine injections necessary for anesthesia.

The writer has employed Iverson's sandpaper technique[1] with excellent results but undesirable aspects are: general anesthesia, hospitalization,

continued on next page

Line A-B represents the depth of the Plastic Planing. Diagram used by Dr. Kazanjian in his discussion of skin grafts, and used here with his permission, and Williams and Wilkins, and publishers of Annals of Surgery where it was originally published, page 873, Vol. 120, 1944.

marked bleeding and possibility of silica granuloma formation.

Kurtin's procedure, described in detail in other publications,[2] will be only briefly described.

After surgically preparing the area, a chilled plastic ice pack containing 5% propylene glycol is applied for twenty minutes. Subsequently, while spraying ethyl chloride, a specially constructed air blower is directed to the area to hasten evaporation and thereby enhance the anesthesia and promote rigidity of the skin. The actual planing is then performed with rotary stainless steel wire brushes of various widths mounted on ½ HP motor capable of 12,000 r.p.m. After the operation capillary bleeding is controlled by moderate pressure. Healing is usually complete in one to two weeks. Severe cases may require two, three or four treatments.

Rationale of treatment: Many post-acne scars involve to a great extent the epidermis and uppermost part of reticular areas of dermis, although some penetrate much deeper. In general, this would be the equivalent of a Thiersch Graft. Furthermore, it has been observed that the donor area of a skin graft containing epidermis but not including significant depths of reticular layer of dermis has regenerated to full thickness and normal texture without scarring.[9] It is a further observation that regeneration of epidermis takes place from hair follicles and sebaceous glands and that these are particularly numerous on the face. At the time of the operation I have frequently experimented by planing small areas on other parts of the body and found that healing was not only delayed but that the regenerated tissue was not always of normal texture.

Although admittedly the percentage of improvement is difficult to measure it would appear to be fifty to eighty per cent and in selected cases even more.

In addition to my own excellent results, the reports of over 1,000[10, 11, 12] cases in the literature are most enthusiastic. Some of the advantages of this method may be mentioned:

1. It is an office procedure.
2. The new ethyl chloride procedure obviates the use of general anesthesia or multiple needle injections.
3. There is no silica granuloma formation.
4. When actually performing the operation, the field is bloodless.
5. The use of small steel brushes permits more differential abrasion in selected areas.
6. Patients are not reluctant to undergo repeated treatment when indicated.

More recently Paul LeVan[13] has advanced what he believes to be a more efficient method of ethyl chloride application which consists of a mechanical spraying apparatus. Frederich Riess[14] has written that he finds dental burrs superior to steel brushes.

CONCLUSIONS

After evaluating various modalities for the treatment of post-acne scarring, the superiority of the Kurtin technique has been emphasized. My views are in harmony with the increasingly favorable reports regarding this procedure.

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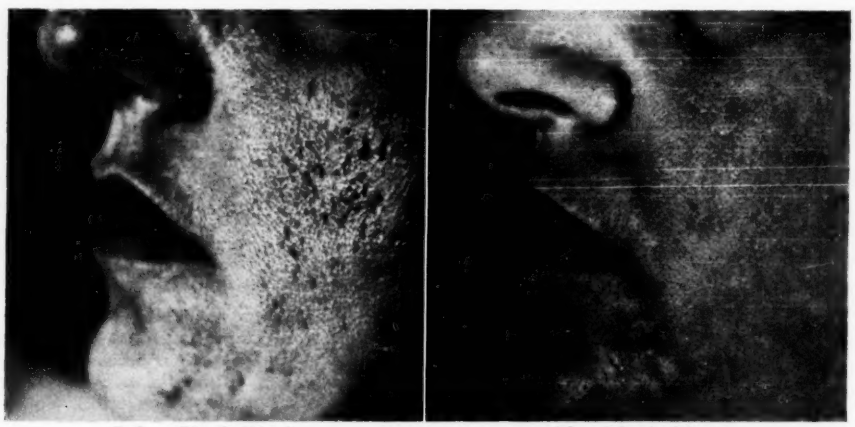
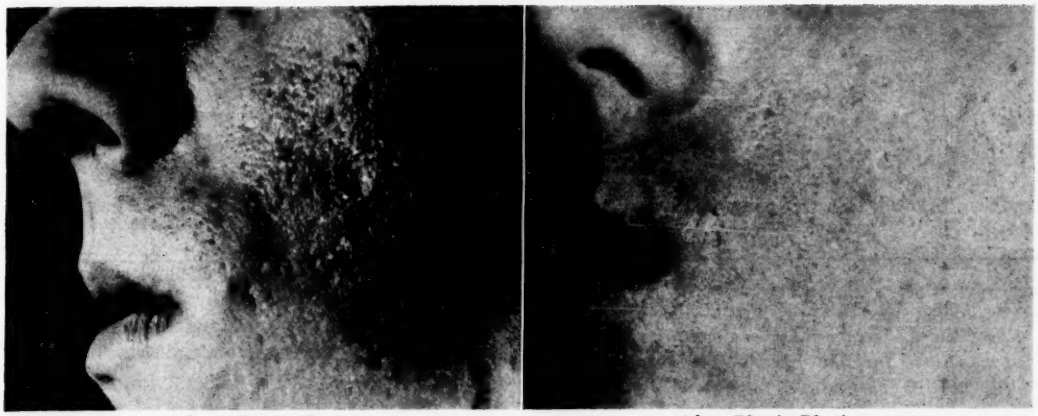


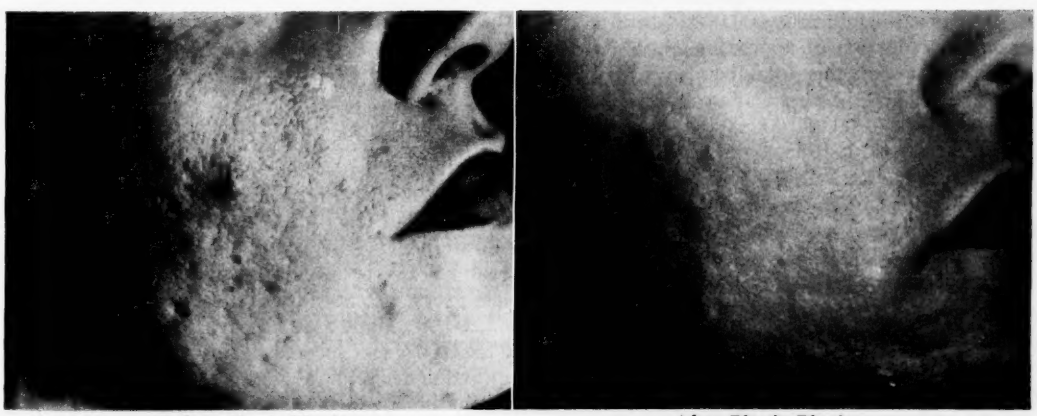
Before Plastic Planing

After Plastic Planing



Before Plastic Planing | After Plastic Planing

Before Sandpapering | After Sandpapering



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THE DOCTOR AND HIS INCOME TAX

VICTOR L. PEDORELLA

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CONGRESS on July 29, 1954, passed the 1954 Internal Revenue Code and on August 16, 1954, the President of the United States by his signature enacted it into law. The new code which replaces the 1939 code and all its subsequent amendments is the result of the most colossal change in the history of the Internal Revenue Code. It not only effected changes which caused taxpayers undue hardships but also made many major changes with respect to administration and procedure in collecting the Federal Income tax.

The revenue effect of the new code for the fiscal year 1955, has been a reduction in individual income tax of approximately $800,000,000.00, and a corporate tax reduction of approximately $620,000,000.00. However, this total loss in revenue of $1,420,000,000.00, has been offset by the increase in revenue of $1,200,000,000.00, arising from the extension to April 1, 1955 of the present 52% corporation income tax rate which was due to expire on April 1, 1954. The net result of the enactment of the 1954 code is a loss in revenue of approximately $220,000,000.00.

The reason for the 1954 code is best expressed in the report of the House Ways and Means Committee which stated "Your Committee has undertaken the most comprehensive revision of the Internal Revenue Law since before the turn of the century and the enactment of the Income Tax." This revision includes a rearrangement of previous laws to place them in a more logical sequence, the deletion of obsolete material and an attempt to express the Internal Revenue Laws in a more understandable manner.

Because of the numerous changes made by the new code, an attempt to cover the subject at hand in one article would not only be too lengthy but it would also result in heavy and tiresome reading. I intend to cover the subject in two articles beginning with this current issue and ending with that for the month of February, as follows:

(1) Changes affecting the individual taxpayer which include all members of the medical profession and

(2) Professional income and expenditures of the medical practitioner reported on Schedule C of the return. I also intend to add my comments regarding errors which in some cases result in the doctor overpaying his tax, and in others are the direct cause of the return being selected for a field examination which not only entails added expense but also involves loss of the doctor's valuable time even though no deficiency is disclosed.

Income Tax Rates

The income tax rates for individuals are the same for 1954 as they were in 1953, except that the new code has combined the 3% normal and surtax (by brackets) into one. In computing tax for 1954 the Internal Revenue Service is using the same rate schedule it used in 1953.

Requirement for filing returns

Under prior law a return was required by all individuals who had gross income of $600.00 or more during the taxable year. This has been continued in the new code for all taxpayers, whether blind or not except it provides that a taxpayer who has attained age 65, before the close of the taxable year will not be required to file a return if his or her gross income during the year was less than $1,200.00. Many aged taxpayers who had less than $1,200.00 gross income during the year were required under prior law to file returns if 65 years of age or more, which was really a futile gesture since there was no tax due, because of being allowed two exemptions of $600.00, one as a taxpayer and one for being 65 years of age or more.

Due date of the return

The due date of the return has been extended from March 15th to April 15th, which allows a taxpayer an additional month in which to file his return. Although this extension is warranted, mere procrastination in filing the return usually results

in undue hardship to the spouse and family of the taxpayer especially in those cases where the taxpayer is suddenly seized with a serious illness, accident, and in many cases death. I have encountered many cases in my years of service in the Internal Revenue Department, in which the taxpayer was the only person who could furnish the necessary data both with respect to his professional and private income and expenditures, which necessitated requests for more than one extension. Where an extension is desired it will be necessary to submit a letter to the District Director of Internal Revenue explaining the reason for the request, which letter must be in his office on or before the due date of the return, and if granted the taxpayer will in turn receive an original and duplicate letter from the director. When the return is finally filed, the original of the letter granting the request should be attached to the return which will eliminate the erroneous assessment of any penalties for late filing.

With respect to extensions, an interest charge of 6% of the tax shown on the return is assessed against the taxpayer, from the due date of the return to date the return is received by the director. A taxpayer who wishes to avoid this interest charge is permitted to submit a check in the amount of the tax he thinks will be due with the extension request letter. The new code provides that no interest will be paid as refunds of tax overpaid until the expiration of forty-five days after the due date of the return. Under prior law, interest of 6% was paid on refunds mailed to the taxpayers after March 15th.

Splitting of Income

Married persons who file joint returns were permitted under the old law to split income, which permitted such taxpayers to divide the taxable income by two, compute the tax and then multiply the tax so computed by two which resulted in computation of tax at the lower bracket rate. The new code has made no change in this respect with married people who file a joint return, except that it now provides that a widow or widower may compute his or her tax by the splitting of income method for the next two years following the death of the spouse, providing that such widow or widower has not remarried during the taxable year and has furnished over one-half support to a dependent, son, stepson, daughter, or stepdaughter whose principal home was that of the surviving spouse. This new law will apply to all such surviving spouses even though their spouse died in 1952, or 1953, provided that the spouses were permitted to file joint returns in the year of the spouse's death even though separate returns may have been filed. Thus:

Spouse died	*Dependent child*	*Re-married*	*Year's tax may be computed by splitting income*
1952	yes	no	1954
1953	yes	no	1954-1955
1954	yes	no	1955-1956

It must be explained that under both the old and new codes, a surviving spouse who has not remarried may file a joint return in the year in which his or her spouse died.

The provision of this section of the law limits this benefit only to surviving spouses who file their returns on Form 1040.

Dependents (new groups added)

Although the 1954 code has made radical changes with respect to the dependency deduction by the addition of two new groups to the list of those who may be claimed as dependents, it has not changed the fundamental rule that a taxpayer in order to claim any of the following listed below must show that he or she furnished over one-half support and such dependent did not have gross income of $600.00 or more during the calendar year in which his taxable year began:

(1) son, stepson, daughter, stepdaughter, or their descendants
(2) brother, stepbrother, sister, or stepsister of the taxpayer
(3) father, mother, or either of their ancestors
(4) stepfather, stepmother of the taxpayer
(5) son or daughter of a brother, or sister of the taxpayer
(6) brother or sister of taxpayer's mother or father and
(7) the in-laws of the taxpayer (divorce does not wipe out the relationship for the dependency deductions purposes)

Permits dependency deduction for non-relatives and cousins

The new code has added the following group who may be claimed as dependents providing such dependents do not have gross income of $600.00 or more, and were furnished over one-half support by the taxpayer during the year:

(1) *Any individual, who though not related to the taxpayer* has lived in the taxpayer's household during the *full calendar year* as a member of such taxpayer's household. The individual may be away from the household of the taxpayer for either schooling, illness, or military duty. The old code caused undue hardship to the taxpayer who maintained in his household a non-relative, in that irrespective of the amount spent for such individual's support, the taxpayer could not claim the credit. This section also covers those taxpayers who have taken for adoption purposes state wards who under

continued on next page

the old code could not be claimed as dependents until the year in which the legal adoption took place. Under the new code the taxpayer would be entitled to claim the $600.00 deduction, if the child has lived in his household during all of his taxable year, irrespective of the fact that legal adoption had not taken place before the close of the taxable year.

Under this provision of the code a cousin who qualifies as a dependent may also be claimed, whereas under the old code a cousin could not be claimed as a dependent regardless of whether he was totally dependent on the taxpayer or not; the cousin so claimed must live in the taxpayer's household for the full taxable year. Examples:

(1) Dr. William Burden and his wife Mary, filed a joint return for the calendar year 1954, and during the full year there lived in their household Miss Jane Brill, age 60. Miss Brill had gross income of $350.00, and during the year she was furnished over one-half her support by Dr. Burden. Under the new code, Dr. Burden could claim the dependency deduction of $600.00 for Miss Brill on his return even though she was not related either to him or his wife.

(2) Dr. and Mrs. John Salk were childless, but on December 10th, 1953, they selected a child four years of age from the State Home and School for the purposes of adoption. The state law provided a probationary period of eighteen months before Dr. and Mrs. Salk could legally adopt the child. Dr. and Mrs. Salk would be permitted to claim the dependency deduction of the child on their 1954 return even though legal adoption would not be effected until 1955.

The new code further provides that a cousin who was furnished over one-half support, and did not have gross income of $600.00 or more during the calendar year of 1954, may be claimed as a dependent if such person was receiving institutional care because of some physical or mental disability, providing that he or she was a member of the taxpayer's household before such confinement. It is noted that this provision differs somewhat with (1) above which requires that the non-related individual, which includes a cousin, must live in the taxpayer's household for the full year. Example:

Dr. James Burrows furnished full support to his cousin during 1954. The cousin had lived with Dr. Burrows since 1947. On March 10, 1954, his cousin was removed to the State Hospital because of his physical condition. Dr. Burrows would be entitled to the dependency deduction on his 1954 return, if there is no subsequent change in the code in this respect. Dr. Burrows would be entitled to the deduction for 1955 because the cousin before being confined in 1954, was a member of his household.

Permits dependency deduction for children having gross income of $600.00 or more

Under prior law, a parent could not claim the dependency credit for a son, stepson, daughter, or stepdaughter if such child had income of $600.00 or more during the taxable year. This caused financial hardship to those parents who had in many cases furnished additional money during the year for their attendance at a preparatory, junior college or an educational institution of higher learning. Many parents whose children had earned exactly $600.00 during the year were prohibited from claiming the dependency credit, resulting in an added tax burden of approximately $130.00 if in lower brackets (considerably more in higher tax bracket). It can be easily understood that if the son or daughter had earned $599.99 the parent would have been permitted to claim the dependency credit.

The new code has rectified this injustice to parent taxpayers, and has provided that a parent who has furnished one-half support for his child during the taxable year, may claim the dependency deduction even though such child has gross income of $600.00 or more during the taxable year provided:

(1) That the child had not attained nineteen years of age before the close of the taxable year or

(2) the child, if over nineteen years of age during the taxable year, was a full-time student of an educational institution for each of *any five months* of the calendar year in which the taxpayer's taxable year begins.

One day or more of any month that the child was a student is computed as a full month in determining the "any five month" qualification. The value of a scholarship, if any, is not taken into consideration in determining support.

It is my opinion that when the regulations for the new code are issued, one who attends night school and works during the day will not qualify as a full-time student.

The term "educational institution" is defined as a school maintaining a regular established faculty, study programs, and normally has a regular organized body of students (grammar, high, preparatory, junior college or university). It does not include non-educational institutions, correspondence schools, and on-the-job training programs. Examples:

(1) Dr. Henry Willis furnished over one-half support during 1954, to his son Henry, age seventeen. Henry attended high school from January 1 to May 10, 1954 (four months), and earned for the remainder of

the year $900.00. Dr. Willis would be entitled to claim the dependency credit for his son because he was under nineteen years of age. If Henry had attained twenty years of age in 1954, then he would not qualify as a dependent of his father, because he had not attended school as a full-time student for any five months of the taxable year.

(2) Dr. William Sears' son William, twenty-five years of age, was a student at Jefferson Medical School in Philadelphia for nine months of 1954. William received a scholarship valued at $1000.00 for 1954. During vacation period, William worked at the Presbyterian Hospital earning $560.00; in addition, he had interest on a savings account of $100.00. Dr. Sears' furnished William $400.00 for expenses and $300.00 for clothes. Dr. Sears would be permitted to claim the dependency credit, since his son qualified as a student and the doctor had furnished $700.00 for his support which was over one-half of $1,360.00 necessary for William's support which included his earnings of $560.00, and interest received of $100.00. If the value of the scholarship was taken into consideration in determining support, Dr. Sears would not have furnished over one-half of William's support. The new law provides that the value of a scholarship is not to be taken into consideration in determining support of a dependent.

Multiple support agreement regarding dependents

The new code provides a new concept for claiming dependency deductions in those instances where two or more related taxpayers furnished support to one whom they could claim as a dependent under the law. It provides where two or more taxpayers furnished such support during the year:

(1) Only the taxpayer who contributed over one-half support during the year may claim the dependency deduction *or*

(2) An election may be made by those taxpayers who furnished support to the dependent providing that no one single taxpayer contributed over one-half of such support and no one contributed 10% or less of such support.

(3) Where an election is made as explained in (2) above a written statement, the form of which is in preparation by the Secretary of the Treasury must be signed by those who did not elect to claim the dependency deduction. With respect to those who did not contribute over 10% of the support required for the dependent, no statement is necessary since the deduction is not permitted of those individuals as follows:

(1) Three brothers *A*, *B*, and *C* furnished support to their dependent brother *D* during 1954 who did not have any gross income whatsoever as follows:

A contributed	$ 580.00
B contributed	360.00
C contributed	210.00
Total	$1,150.00

Since *A* contributed over one-half of $1,150.00 there is no election, *A* is the only one who is permitted the deduction.

(2) Assume in (1) above that

A contributed	$ 590.00
B contributed	210.00
C contributed	380.00
Total	$1,180.00

Since none of the brothers individually contributed over one-half support, either may claim the deduction.

(3) Assume in (1) above

A contributed	$ 590.00
B contributed	580.00
C contributed	120.00
Total	$1,290.00

In this case either *A* or *B* may claim the deduction but *C* is not considered since he did not contribute over 10% of the $1,290.00.

Annuities

Under prior law an annuitant was required to report 3% of the cost of an annuity as taxable income, the balance of the amount received was deemed to be recovery of cost after which the annuity payment was taxable in full.

Under the new code an annuitant must determine the expected return from the annuity. When it is payable for a specified number of years the expected return would be the annual annuity payments multiplied by the number of payments called for under the contract whereas if the annuity provided for life payments it would be necessary to refer to the life expectancy table and multiply the life expectancy by the annual payments to be received as follows:

(1) On Jan. 7, 1954, an annuity matured which Dr. William Williams, age 55, purchased in 1934. It cost him $30,000.00 and was to pay him $4,000.00 annually for 10 years beginning Jan. 8, 1954. The portion of each annuity payment that is excluded from taxes (return of capital) is determined by arriving at his expected return from the

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HISTORY TAKING IN ALLERGIC DISEASES*

(With Special Emphasis on Childhood Asthma)

STANLEY S. FREEDMAN, M.D.

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AMONG the many procedures available for the diagnosis and management of allergic diseases, first and foremost is a thorough and complete history. There are other diagnostic procedures such as skin testing, eosinophile counts, x-ray examination and vital capacity measurements, but these will contribute much less to the total understanding of a case of allergy, than would a good history.

An allergic history does not end with the first interview. As the patient is observed and additional facts become known, the history will be augmented accordingly, and so will be the management of the patient. Chart 1 may be used as a guide when taking an allergic history.

Family History

The family history is of importance, as it may provide information on prognosis. A bilateral family history of allergy may indicate a stormy course. Where there are several non-allergic siblings in the family, one may feel relieved. Whereas if there are no siblings as yet, one wonders whether future siblings will or will not also have allergic disease.

Past History

Infantile colic, regurgitations, vomiting, frequent formula changes, and other past abnormal gastrointestinal manifestations may indicate food allergy, especially milk allergy. A history of foul, bulky, greasy stools, in infancy, requires that we rule out cystic fibrosis of the pancreas, which in later childhood may simulate bronchial asthma.

Frequent bouts of sniffling, rhinorrhea, and colds in infancy and in childhood, are often early manifestations of respiratory allergy. What we often consider upper respiratory infections may be and often are upper respiratory bouts of allergy, masked by concomitant infection. Attacks of the croup often precede clinical asthma.

*Read at the New England Pediatric Society Session in Providence, R. I., May 12, 1954.

From the Rhode Island Hospital Pediatric Allergy Clinic.

Onset

The age of onset of asthma is significant. Dr. William Buffum[2] has called attention to the fact that often bronchial asthma begins in the first year of life. If so, it is likely to run a severe course. 19% of the 250 patients of Buffum's series had symptoms during the first year of life. The circumstances leading up to the first attack of asthma are important. If a respiratory infection accompanies the first attack, one may assume that similar future respiratory infections will likewise initiate or predispose to more asthma. If the first attack followed a visit to the zoo, it implies that animal dander is at fault. The season of the year when the first attack occurred should be checked with the prevailing pollen or mold season. One should remember however, that more than one season is required for the clinical diagnosis of seasonal allergy.

When asthma follows pertussis or pneumonia, and if symptoms and physical signs continue, one should keep in mind the possibility of coexisting bronchiectasis. In 160 cases of bronchiectasis studied, Field[1] found that pertussis and pneumonia are the commonest predisposing diseases in childhood. Therefore it is logical to assume that in some cases where asthma followed pertussis or pneumonia, and especially if the asthma is not easily controlled, early bronchiectasis may be a complicating factor.

Frequency and Duration of Attacks

When a child has only one or two attacks per year, it is very likely due to a respiratory infection. If attacks occur frequently the etiologic mechanisms may be numerous and complicated. It is well to note the duration of the attacks. Brief wheezy spells will respond to almost all types of simple medications. Long drawn out attacks will require careful planning and complicated treatments. A special effort should be made to ascertain the patient's status between attacks. When a child wheezes continually even between attacks, we may suspect a foreign body or a congenital anomaly. Fibro-cystic disease of the pancreas may be present and should be ruled out. Last but not least, a common environmental allergen may be the cause of continuous wheezing. The same may be said about food allergens.

Season

Of greatest importance is the repeated annual seasonal incidents or flare-ups of allergic manifestations. The discovery by Noon of England, in the early part of this century, of the relationship between seasonal pollination of certain plants with clinical seasonal hay fever and asthma is a bright chapter in the history of allergy. Many patients make their own diagnosis when they discover that their allergies appear the same season year after year. It is difficult for most patients to remember specific dates, but they may recall holidays during which time their symptoms occurred.

Chart 2 shows the pollination seasons of the important hay fever producing plants in this area. A house dust season is included, although it is by no means as definite as the pollen seasons. Many authors believe it exists in early fall, corresponding to the time when the human family turns on the heating system and goes inside. The radiating heat refloats all kinds of allergenic particles into the air, which during the summer months settled undisturbed in crevices, corners, and similar other places.

There are two (2) types of seasonal allergic manifestations:

1. *Purely seasonal hay fever or asthma.* Symptoms are confined to the time when the specific disease producing pollens are in the air. The symptoms subside with the disappearance of these pollens from the atmosphere. Here the diagnosis is made without difficulty, especially after the first or after the second year of the disease.

2. *Perennial symptoms with seasonal flare-ups.* In this instance, a patient has symptoms all year round, but in addition there are distinct seasonal flare-ups. The seasonal character may be overlooked, unless the physician keeps this possibility in mind. In this situation a positive skin test is of great value and is often a decisive factor in establishing the fact that a seasonal pollen or mold is associated with the seasonal flare-ups. (See chart 2.)

Known Sensitivities

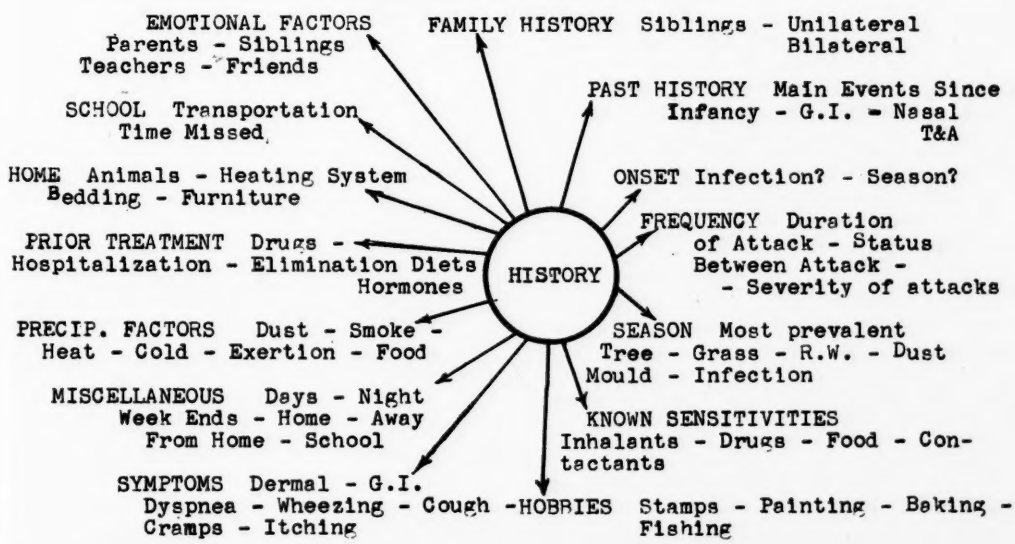
Patients or parents frequently are aware of one or more items in the diet or in the environment which they think are capable of provoking symptoms. These suspected provocators should be listed, and should be verified, or disproven. Otherwise the patient may be denied a food or some worthwhile object unjustly, or may be exposed to or given something to which sensitivity exists. Drugs and biologicals which have previously been given should be listed and their reactions noted if any.

Hobbies

The hobbies of an asthmatic patient may profoundly influence the course of the disease. Fish glue sensitivity would not permit an asthmatic patient to become a stamp collector. It is not yet known whether paint and turpentine are truly allergenic, or whether they act as respiratory irritants. However, many asthmatic patients will wheeze

continued on next page

Chart 1, Showing Salient Features of an Allergic History



when exposed to the odor of fresh paint, and these patients find it necessary to completely avoid paint.

The importance of wheat flour as an inhalant allergen is often overlooked. The child who helps her mother with her baking, the child whose father is a baker, or the child who lives above a bakery is abundantly exposed to raw flour. Fish and shellfish may be allergenic, either as ingestants or as inhalants. The four-year-old son of a Providence surgeon, who is exquisitely allergic to a variety of foods, and whose asthma is under control developed intense wheezing and choking when he came in contact with small live crabs on the beach near his summer home. If this fact were not known to the parents, the boy might have been given crab meat to eat with possible catastrophic results.

Symptomatology

It is desirable to obtain a detailed description of the symptoms during an attack of asthma. Such a description may clarify the diagnosis of asthma when it is in doubt. It will aid in the planning of the treatment of acute episodes. If attacks are characterized chiefly by dyspnea and wheezing a broncho-dilator drug such as ephedrine, in combination with a sedative, is all that may be needed. If these symptoms are severe, adrenalin may be given every half hour. Children often have violent gastrointestinal upsets which accompany the attack of asthma. If so, subcutaneous adrenalin or rectal aminophyllin may be the answer.

When severe coughing accompanies the attack, we should note whether it is a productive cough. If so, what is the nature of the secretions? If thick and tenacious, iodides or terpin hydrate should be included in the early treatment of the attack. Not infrequently during an attack of acute asthma, secretions are so copious and so thick that the patient is unable to cope with the situation. This is a most critical stage in acute asthma. At this point air is prevented from entering the terminal bronchi because of the obstructive secretions. Whatever air does enter the lungs is retained by virtue of the existing mucosal edema and bronchospasm. Residual air volume and intrapulmonary pressure is increased. Tidal air is diminished. The patient will soon be exhausted. This is probably the only time when the very life of an asthmatic patient may be in danger.

When the history reveals that prior attacks reached the stages just described, then we should be prepared for prompt heroic medical treatment, including the use of aminophyllin, iodides, and ACTH intravenously. Sometimes bronchoscopy under general anesthesia has to be resorted to.

If elevated temperature is the rule in many of the previous attacks, we may assume that respiratory infection is a major trigger. Cyanosis in bronchial asthma is a grave symptom. If present it presents an indication for the use of oxygen. There may be other symptoms, which if listed while the history is taken, will enhance our understanding of the case.

CHART 2

Showing the Pollination Seasons in the R. I. Area, Also a Probable House Dust Season

	Species	*Pollination Time*
TREES	Maple	March, April
	Birch	May
	Oak	May
GRASSES	Timothy	June, July
	Orchard Grass	June, July
	June Grass	June, July, August
RAGWEED	Short R.W.	August, September, October
	Giant R.W.	August, September, October
HOUSEHOLD DUST		October, November, December

Precipitating Factors

Patients or parents often know or think they know one or more items that are predisposing to an attack. It may be a food, an animal, a hay ride, exertion, or a particular climate. These items represent clinical causes of asthma. Although we cannot always demonstrate their importance immunologically, we cannot ignore them either. In the case of a suspected food, an effort should be made to verify its clinical importance, and if so to avoid it. If, however, it is shown by trial diets that it has no clinical importance, the child should not be deprived of it. Needless to say, every predisposing factor should be eliminated.

The Home

Domestic animals, feather pillows, old or antique overstuffed furniture, stuffed toys, and many other household articles make up the house dust, which is highly allergenic to a large percentage of asthmatic patients. Fumes from the kitchen oil stove may be the causative agent in certain cases of asthma. Molds or dampness from a poorly ventilated cellar may also be a factor. Frequently it will be of help for the physician personally to visit the home, in order to make a direct inspection of the patient's immediate surroundings.

School

The actual number of school days missed per given period of time is a fair index of the extent of the child's asthma. Occasionally a youngster experiences an excessive amount of asthma in the school room. Presumably the blackboard chalk dust may be a factor. The child who has to walk a long distance may arrive at school with wheezy respiration caused by exertion. He may thus have a poor day at school. By providing transportation, preferably in the family car, the child will enter his classroom in a much better condition to assume

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The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society

106 Francis Street, Providence, Rhode Island

THE CHALLENGE TO MEDICAL EDUCATION

THE FUTURE of this nation depends upon the development and preservation of its resources. Of these, there is nothing more vital than the health of its citizens. To preserve this priceless possession by preventive and therapeutic measures is the function of the medical profession. Even as the efforts of the profession become more effective year by year, and the level of general health and longevity of the people is increased, so also do these efforts become, of necessity, more complicated and more expensive. In the same way, it takes progressively more time and effort, and more money to train a young physician to the necessary level of competence in the application of these measures. In other words, the cost of medical education progressively goes up, but the private sources of financial support of such education do not.

In Public Affairs Pamphlet, No. 214,* under the above title, "The Challenge to Medical Education," Robert M. Cunningham, Jr., for nine years Editor of MODERN HOSPITAL, has ably summarized the situation. He states that "the doctors who provide our medical care are a national resource of surpassing importance," and then goes on to show that the maintenance of the supply of these doctors is gravely threatened by a lack of financial support. This, of course, is no news to physicians generally, who, as pointed out in the pamphlet, have been contributing generously, either through the American Medical Education Foundation or by direct contributions to the medical schools where each was trained. Businessmen and industrialists have given their support through the National Fund for Medical Education. But, as Mr. Cunningham remarks, "The $7,000,000 provided so far by business and the medical profession . . . is no more than a strong beginning toward a real solution to the financial problems of our medical schools." It appears certain that these sources alone cannot make up the difference between the $3,000 to $4,500 a year it costs to educate a medical student and the $600 to $900 a year that he pays in tuition. To put it simply, we need more doctors, who must be educated at increasing cost, and the money to support this essential need is not forthcoming. As stated in pamphlet 214, "Plainly, more and more groups

continued on next page

*Public Affairs Pamphlets, 22 East 38th Street, New York 16, N. Y.

must accept an increased share of responsibility for support of medical education if we expect the schools to perform fully and effectively in the future."

The obvious alternative is complete government financing, which means political control. It occurs to us that the pharmaceutical industry, whose work is necessarily so closely connected with that of the medical profession, might well save most of the money spent in very expensive illustrated brochures and similar material, by which each firm seeks to "educate" the practitioner to use its particular products, and could well turn such funds over to be used in the fundamental educational processes of the medical schools and hospitals. Such contributions could, and should receive full credit, and would constitute the most effective and ethical advertising to the firms which so contribute, while making a real move in support of the work on which the welfare of these firms as well as the health of the public depends. This may be one of many sources of support that must be tapped if medical education in this country is to remain free and to progress.

THE DOCTOR AND HIS INCOME TAX

In this issue we publish the first of two articles on the effect of the new Internal Revenue Code upon the physician as an individual taxpayer. The second article which is scheduled for our next issue will deal with the problems the physician faces in resolving his federal taxes in his work as a medical practitioner.

Written by an accountant with more than two decades of service locally with the department of internal revenue of the Federal government, the articles bring to our membership authoritative and informative presentations that should be most helpful.

Taxation questions at their simplest form are vexing, and we are sure that Mr. Pedorella has found a way to clarify the new provisions of the 1954 code that will prove lucid to every taxpayer in our membership.

GONE AT SIXTY

When automobiles first started to speed along our roads we recall that the expression of that day was that a person was "going like sixty."

Recently, we read in the daily press that a congressman from one of our neighboring states plans to introduce in the Congress of the United States this year a bill to reduce the retirement age under the social security system to sixty years. We daresay that his proposal will not be the only such vote getting one of this type to be introduced. Thus it would appear that our legislators will soon have us "gone by sixty."

The fear of insecurity that has arisen in recent years is now beginning to have its ramifications upon the industrial pattern of the country, as well as upon the individual citizen. People have lost confidence in opportunity, and in themselves. The answer, contrary to what federal legislators may believe, is definitely not in programs calling for what amounts to compulsory retirement at the age 60.

Within a week of the announcement of our congressional member that he would seek a lower retirement age, the press carried the warning of Secretary of Labor Mitchell based on a year long Labor Department study that

> **Unless something is done to give them (the adult population) job opportunities, an estimated half of our adult population will be condemned to a life of economic uselessness.**

The Labor Department study pointed out that unless prejudices about hiring older workers are quickly overcome half the nation's adult population will be jobless twenty years hence. Most of the objections to hiring older workers are mere facies, the department stated, for in truth their performance is equal or superior to younger workers, their judgment is better, and they have better safety and attendance records.

In urging the medical profession, and particularly the medical directors of life insurance companies, to fight the widespread retirement at the arbitrary age of 65, Dr. Karl W. Anderson, chairman of the medical section of the American Life Convention, told that group last summer

> "The Government in its attitude towards social security is at least suggesting, and many times forcing, a premature retirement. The original idea of social security—to keep people away from the poorhouse—has been lost sight of and somehow the idea has crept in that social security is an adjunct to retirement funds. So now to enjoy this luxury it is necessary for people to lay down their tools and let their skills grow rusty starting at the age 65 (and at age 60, according to the new proposals). Time and social security experience itself are proving how wrong this concept was. The average age at which American citizens claim their first social security pension check is 69!"

Predicting that the United States Government will eventually have to reverse its attitude toward retirement, Dr. Anderson stated "I do not believe the lengthening life span and the growing population of people living beyond the age of 65 will permit even the world's most productive nation to support economically a system in which so large a percentage of its members are totally unproductive and therefore totally dependent. We must encourage people to continue work for economic reasons as well as for their own happiness."

The viewpoint of the physician meeting the older

age person in his daily practice was ably set forth recently by Dr. Charles Sellers in an editorial in the DETROIT MEDICAL NEWS on *The Tragedy of Retirement* in which he points out that

"Physicians are in an exceptionally unique position in that they are not forced to retire but may decrease the work load without losing contact with medicine and doctors. Illness may be the only exception and many ill physicians continue some activities because they love their work.

Retirement is rejection.

Rejection is devastating, both psychologically and sociologically. It decreases one's statute, deflates one's ego . . . (and) to be "put on the shelf" intimates uselessness and few of us would accept such an appraisal willingly. . . .

Retirement is not the rosy Nirvana that some hard-working persons envision it to be. After a few weeks or a few months, it becomes a dreary existence that gradually becomes more and more detached from the rest of the work-a-day world. . . ."

What is needed is less planning by legislators on how to make people prematurely idle, and more planning for old age security on a healthy basis, with a sober evaluation of our existing realities and an intelligent approach to the transition to a sound and healthful concept of retirement.

SURGICAL MEETING FOR ALL DOCTORS

In this issue you will find the program of the Sectional Meeting of the American College of Surgeons to be held here on March 3-5, and the College wishes us to emphasize that *all our members* are invited. We think that it would be a smart thing for everyone to go, even those not surgeons. The modern surgical meeting is a very different thing from what it was not too many years ago. It is not taken up with the details of operations and descriptions of new techniques. Any medical man should get much out of many of these papers.

In fact, the old division of medical and surgical is rapidly becoming obsolete. No case is in either category until it has been studied. Every surgical case needs a great deal of medicine (not drugs, but the careful study that a good internist gives his cases).

You will hear a great deal of physiology discussed by some surgeons who are excellent physiologists. The last Sectional Surgical Meeting here was a great success. This one evidently will be the same.

***YOU* ARE INVITED . . .**

See pages 56, 57, 58

HISTORY TAKING IN ALLERGIC DISEASES

concluded from page 30

his school duties unhindered by his physical handicap. In some communities the Red Cross will provide such transportation.

Miscellaneous

We should find out whether a patient is worse during the day or during the night. By far too many patients find their asthma more threatening during the hours of the night. The reason is not known. Is it the temperature which is at fault? Is it due to common environmental allergens which have not been brought under control? Perhaps it is related to the physiology of fatigue. When a patient is experiencing more difficulty on week ends, one will inquire how the patient's habits and activities differ on week ends from those on week days. Is the patient better when away from home? If so we may again ponder over house situations.

Emotional Factors

An allergic history is not complete without surveying the emotional background of the patient. An attempt should be made to determine if the child is properly adjusted at home, and at school. Is the child under stress or tension? Naturally a happy, serene home is essential for a child plagued with bronchial asthma.

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CHECK MARCH 7

The Doctor's Retirement Problem

will be discussed at the meeting of the

PROVIDENCE MEDICAL ASSOCIATION

THE DOCTOR AND HIS INCOME TAX

continued from page 27

annuity which is $40,000.00 (10 payments multiplied by $4,000.00) as follows:

Amount received each year	$4,000.00
$\frac{30,000.00}{40,000.00} \times 4,000.00$	3,000.00
Taxable in full each year	$1,000.00

(2) If the annuity provided for life payments then the expected return would be determined by the life expectancy of Dr. Williams at age 65. Assuming in the above that all the facts are the same except that it provided for life payments and Dr. Williams' life expectancy was 15 years by reference to the life table, the expected return would be $60,000.00 and the amount of each payment excluded would be determined as follows:

Amount received each year	$4,000.00
$\frac{30,000.00}{60,000.00} \times 4,000.00$	2,000.00
Taxable in full each year	$2,000.00

If Dr. Williams outlived his life expectancy he would still be required to pay tax on $2,000.00 of each annual payment.

Endowment policies

Where an endowment policy matures during the year the difference between the cost of the policy and the amount payable at maturity is taxable except that the difference may (taxpayer's option) be allocated one-third in the year of maturity and one-third may be allocated to each of the two preceding taxable years. Example:

Dr. Henry Brown in 1933, purchased an endowment policy which cost him $16,500.00, and July 7, 1954, it matured, Dr. Brown was paid $19,800.00. He could elect to allocate the excess of $3,300.00, in his returns of the years 1954, 1953 and 1952. This method would probably result in a tax savings for Dr. Brown in that it would reduce his tax bracket. There would be no need to file amended returns for 1952 and 1953. Dr. Brown could recompute his tax for 1952, and 1953, by attaching a statement to his 1954 return and adding the additional tax computed with respect to each of the years 1952 and 1953 to the 1954 tax.

Life Insurance

The proceeds of life insurance received by a beneficiary because of death of the insured were not taxable under the old law and are treated in the same manner under the new code. Where the beneficiary leaves the proceeds with the company, and is paid interest the payment is taxable in full as interest received.

Where insured dies after Aug. 16, 1954

Where the proceeds are left with the company (option by insured or beneficiary) with provision that the annual payments be made either over a fixed number of years or for life, such payments are treated the same as annuity. The cost basis will be the proceeds of the life insurance except that a surviving spouse may exclude an additional $1,000.00 from the amount subject to tax each year. Example:

Dr. James Hough died Sept. 17, 1954, and his wife Mary received $40,000.00 as beneficiary of the doctor from the A.B.C. Life Insurance Co. Mrs. Hough elected to receive for ten years annuity payments of $6,000.00, in this case the expected return would be $60,000.00 (10 × $6,000.00). The taxable portion of the $6,000.00 annual payment would be determined as follows:

Amount received each year		$6,000.00
$\frac{40,000.00}{60,000.00} \times 6,000.00$	$4,000.00	
Wdow's exclusion	1,000.00	5,000.00
Taxable to Mrs. Hough each year		$1,000.00

If Mrs. Hough elected to receive the payment over her life expectancy the expected return would be computed at the annual amount received multiplied by her life expectancy.

Where a taxpayer purchases a life insurance contract and continues the payments, the proceeds received by him on death of the insured are treated as follows:

Dr. Henry Serra purchased a $50,000.00 life insurance contract from the insured for $18,000.00 in 1948, for which he was made a beneficiary. Dr. Serra paid all the premiums from that date to the date of the insured's death on November 13, 1954, which totaled $13,000.00.

Amount paid for policy	$18,000.00
Premiums paid	13,000.00
Total cost of policy	$31,000.00
Amount received	50,000.00
Taxable in 1954, in full	$19,000.00

Surrender of life insurance contract

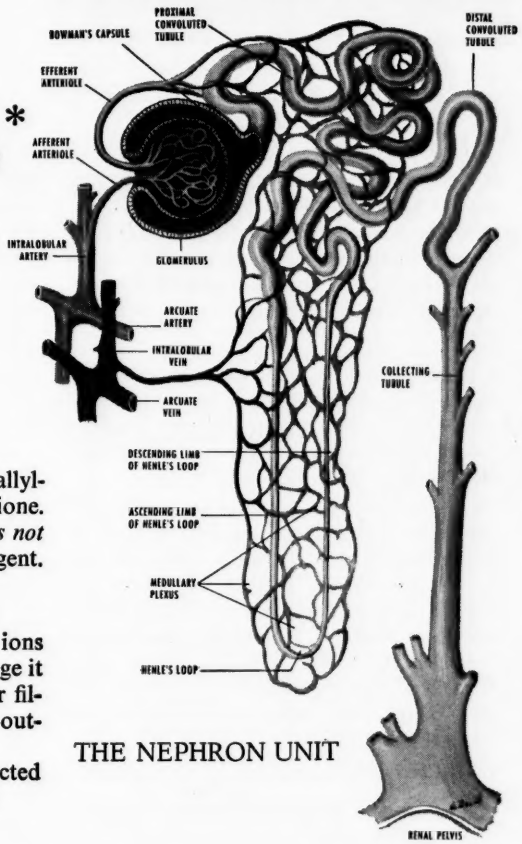
The difference between the amount received on surrender of a life insurance contract and its cost is taxable in full in the year of surrender where the cost of the policy to date of surrender is more than the amount received; the loss sustained is not allowable as a deduction on the income tax returns (losses sustained on the sale of personal assets are not deductible for income tax purposes). Dividends received from an insurance contract while a policy is in force are not taxable; they are treated as a *reduction in cost of the policy.*

continued on page 36

A *NEW* PRODUCT OF SEARLE RESEARCH

ANNOUNCING MICTINE*

New, Effective, Non-Mercurial Oral Diuretic



THE NEPHRON UNIT

STRUCTURE

Mictine, brand of aminometramide, is 1-allyl-3-ethyl-6-aminotetrahydropyrimidinedione. Mictine—result of years of research—*is not* a mercurial, xanthine or sulfonamide agent.

ACTION AND EFFECTIVENESS

Mictine inhibits reabsorption of sodium ions by the renal tubule. In therapeutic dosage it has not caused any effect on glomerular filtration rate, renal plasma flow, cardiac output, heart rate or blood pressure.

Approximately 70 per cent of unselected edematous patients respond to Mictine.

TOLERANCE

Mictine is without serious toxic effects as used. It has not produced any alteration in the blood or blood-forming organs or in renal or hepatic function. At times headache or gastrointestinal symptoms (anorexia or nausea but rarely vomiting or diarrhea) have occurred, however, these effects may be reduced to a minimum by giving Mictine on an interrupted dosage schedule.

ADMINISTRATION

Mictine is useful primarily in the *maintenance* of an edema-free state and in the *initial and continuing* control of patients in mild congestive failure. In such patients, dosage is one to four tablets daily *with meals*, in divided doses on an interrupted schedule. An interrupted dosage schedule may be accomplished by giving the drug on alternate days; or by its administration for three consecutive days and its omission for four consecutive days.

Mictine also may be used for *initial* diuresis in *more severe* congestive states, particularly when mercurial diuretics are contraindicated. In these more severe congestive states, dosage is four to six tablets daily *with meals*, in divided doses on an interrupted schedule similar to those mentioned above.

SUPPLIED

Uncoated tablets of 200 mg. in bottles of 100.

**Trademark of G. D. Searle & Co.*

SEARLE

THE DOCTOR AND HIS INCOME TAX

continued from page 34

Sale of Personal Residence at Gain

Under the old code a taxpayer who sold his personal residence at a gain would not be required to pay tax on the gain if he or she expended the full selling price of the old residence towards the purchase of a new personal residence provided:

(1) A new personal residence was purchased either one year before or one year after the sale of the old residence *or*

(2) began construction of a new personal residence within one year after the sale of the old residence and occupied such newly constructed residence within six months thereafter.

The new code provides the same condition noted above except that a taxpayer would be permitted to deduct any selling and fixing up expenses incurred within ninety days period prior to contract of sale of the old residence as follows:

(1) Dr. John Devoe on January 10, 1954, purchases a personal residence at a cost of $20,000.00. On January 21, 1954, he sold it for $30,000.00, having expended $1,200.00 for paint and repairs prior to selling and paid $800.00 in selling commissions. On December 10, 1954, Dr. Devoe purchased another residence which cost him $26,000.00. Dr. Devoe would pay tax on the following gain:

Selling price of old		$30,000.00
Fixing up	$1,200.00	
Selling commissions	800.00	2,000.00
Net selling price		$28,000.00
Cost		20,000.00
Actual gain		$ 8,000.00
Net selling price		$28,000.00
Cost of new residence		26,000.00
Taxable gain for 1954		$ 2,000.00

(2) Assume that in (1) above all the facts are the same except that Dr. Devoe paid $28,000.00 for his new residence, he would not be liable to tax on the sale since he had expended the full actual gain in acquiring his new residence.

Accident and Health Benefits of Employees

Although the subject does not directly concern itself with the medical practitioner, he may be called upon to furnish statements to employers on behalf of his patients who are affected. The new code provides the following exclusion from the employee's gross income if he is reimbursed for the following expenses by an employer-financed accident and health plan:

(1) *Medical care payments.* Any reimbursement received from an employer's financed plan for medical expenses incurred by the employee, his spouse or any of his dependents would be excluded from the employee's gross income, whether he paid the expense so incurred in the year he received the reimbursement or not. The exclusion would not apply if the employee deducted the amount so expended as medical expense on his return.

(2) *Payment for permanent injury.* Any payment received from such a plan by an employee for the permanent loss or loss of use of a member or function of the body, or the permanent disfigurement of either the employee, his spouse, or his dependents would be excluded from the employee's gross income in the year of receipt. The period of absence from work because of this injury would have no bearing; such an absence could be for one day, one year or more.

Compensation for loss of wages

Any employee who, because of illness or personal injury, receives payment for loss of wages under an employer's financed plan, would be permitted to exclude from his gross income the first $100.00 of such payment provided:

(1) When the absence is due to *illness,* payment received for the first seven-day period of such absence would be fully taxable unless the employee was hospitalized for one day (overnight) during the period of such absence.

(A) Henry Shivers, an employee of the New Method Corporation was absent from work four weeks, because of such illness; he was not confined to a hospital at any time during the period. His employer's financed plan reimbursed him for the loss of his wages to the ex-

tent of $120.00 a week. Mr. Shivers' payment would be treated as follows:

Period	*Excludable*	*Taxable*
1st week	none	$120.00
2d week	$100.00	20.00
3d week	100.00	20.00
4th week	100.00	20.00
Total	$300.00	$180.00

(B) If in (a) above Mr. Shivers was ordered to a hospital for at least one day during the period of absence then the first $100.00 of the weekly payment received would be excluded from his gross income.

(2) When the absence is due to personal injury (whether on or off the premises), the first $100.00 of any payment received for loss of wages would be excluded whether he was confined to a hospital or not during the period of his absence.

Contributions

Under prior law a taxpayer was not permitted to deduct in excess of 20% of adjusted gross income (line 6 page 3 of Form 1040) with respect to contributions made during the year to charitable, scientific and educational organizations. The new law has made a change in this respect; it now permits a taxpayer to deduct an additional 10% of adjusted gross income for contributions made to

(1) an educational institution which has normally a regular faculty, curriculum, and a regularly organized student body.

(2) a hospital which provides medical care, educational or research facilities.

(3) a church, conventions of or associations of churches.

In addition the taxpayer is also permitted to further deduct a maximum of 20% of adjusted gross income with respect to all contributions to other charitable organizations to which is added the balance remaining after the 10% deductions permitted in (1) (2) (3) above.

Dr. William Jones had adjusted gross income of $12,000.00; during the year he contributed to St. James Episcopal Church, $1,000.00 and also contributed to R. I. Hospital, $500.00. He also donated to the American Red Cross $1,800.00. His contribution deduction would be determined as follows:

Adjusted gross income			$12,000.00
Contributions	*Amount*	*Allowable*	
St. James Church	$1,000.00		
R. I. Hospital	500.00		
Total	$1,500.00	$1,200.00	(10%)
Balance	300.00		
Red Cross	1,800.00	2,100.00	
Total deduction			$3,300.00

A taxpayer who donates stock, securities, or an asset that has appreciated in value will be permitted to use the fair market value of the gift as the basis of his contributions whereas if he sold it he would be required to report and pay tax on the gain even though he gave the proceeds to a charitable organization. Examples:

(1) Dr. James Tappan in 1950, purchased 100 shares of A.B. Motors common stock at a cost of $2000.00. On July 1, 1954, it had a fair market value of $10,000.00. If Dr. Tappan sold the stock on that date and gave the cash to the Red Cross, he would be required to report a long-term capital gain of $8000.00, in his return and pay tax on 50% or $4000.00, and of course would be allowed to enter in his return a charitable contribution of $10,000.00, whereas if Dr. Tappan transferred the stock to the Red Cross he would report no gain and still be treated as having given $10,000.00 to the Red Cross.

(2) Assume in (1) above that the stock cost Dr. Tappan $10,000.00 in 1940, and on July 1, 1954, it had a fair market value of $2,000.00, then it would be more advantageous for the doctor to sell the stock and make the $2,000.00 donation in cash to the Red Cross, he would then be permitted a long-term capital loss of $8,000.00, which could be used in that year against other capital gains, if any, and if not he would be entitled to deduct $1,000.00 against other income and carry the loss of $9,000.00 to the next five succeeding years if necessary.

A taxpayer may give an existing policy on his life to an exempt organization; the basis of the gift will be its value at the time of the gift (cash surrender); he must assign all rights in the policy irrevocably to the charity, and also make it the irrevocable beneficiary. In subsequent years the taxpayer may deduct the premium he pays on the policy as a charitable contribution as follows:

Dr. William Sullivan on Dec. 10, 1954, assigned a $100,000.00 insurance contract on his life to St. Joseph's Hospital. He assigned all rights and interest to the hospital, and in addition he made it the irrevocable beneficiary and also agreed to pay the annual payment of premium of $7,000.00. The policy on the day it was assigned had a value of $10,600. Dr. Sullivan would be treated as having made a charitable contribution of $10,600.00 on his return for 1954. The doctor

continued on next page

would also be permitted in each of the subsequent years to treat the premiums he paid of $7,000.00 as charitable contributions.

Interest Paid

All interest paid on personal transactions are deductible in full on page 3 of the return if the taxpayer uses itemized deductions. A list of deductible and non-deductible interest payments follows:

Deductible

Interest paid on mortgage whether on personal home or professional building.

Interest paid on purchases of equipment on installment basis if identified.

When the interest is not identified on an installment purchase, the new law provides that a taxpayer may add his balance for each month, divide by 12 and multiply the result by 6% as follows:

Dr. Henry Williams on January 10, 1954, purchased equipment for his office at a cost of $3,800.00 which included interest charges for 20 months. He paid $800.00 and $150.00 a month beginning February 10, 1954. The total of the monthly balances for 1954 would be $26,100.00. The interest deduction for 1954 would be computed as follows:

Total monthly balance	$26,100.00
Divided by 12	2,175.00
Interest deduction, 6% of above	130.50

Interest paid by an occupant of cooperative house or apartment project.

A life insurance loan if the interest is paid in cash.

Interest paid on a loan from a corporation of which the borrower is an officer or stockholder providing the loan is a *bona fide* debt.

Several years' interest paid in advance in one year by a cash basis taxpayer.

Non-deductible

Interest paid on loans used to purchase tax-free bonds of governments or State, etc.

Interest paid to a member of a taxpayer's family unless he can prove that it is legitimate loan and there is a legal debtor-creditor relationship between the taxpayer and the member of family.

Interest paid on mortgage on real estate or home of taxpayer's mother, father or relatives, or other individual.

The interest paid by the taxpayer is deemed to be a gift since there is no legal obligation upon him to pay.

Interest paid where there is no legal obligation to pay.

Interest on a loan or insurance policy where the interest is not paid by the insured when due and the company reduces the cash surrender value of the policy by the interest payment due.

Loans of $200.00 and borrower receives $180.00, there is no interest deduction until the $180.00 is paid, the balance of $20.00 will be deductible as interest in the year in which it is paid.

Amounts paid where there is no debt with respect to the person paying such so-called interest.

Where a taxpayer has borrowed money from a bank and gives a note for the interest when due.

Interest on loans used to purchase tax-free obligations.

Taxes

Under the old law, taxes paid were deductible in the year in which they were paid by the person on whose property they became lien. There has been no change in this respect except in those cases in which the taxpayer sells the property, then both the seller and the purchaser may deduct the tax paid proportionately as follows:

(1) the seller may deduct that portion of the tax allocated to date of sale, *and*

(2) the buyer may deduct that portion of the tax allocated from date of purchase to the end of the taxable year as follows:

(1) Dr. Henry Billard sold his personal residence to Dr. William Burdick on July 1, 1954. On January 9, Dr. Billard paid the full year's tax of $820.60 (January 1 to December 31). Dr. Burdick paid to the seller $410.30 as his portion of tax to June 30. Dr. Billard will be permitted a tax deduction of $410.30 if he itemizes his deductions and Dr. Burdick may take a deduction of $410.30. Under prior law only Dr. Billard could have deducted the full tax paid of $820.60 and Dr. Burdick would have treated the $410.30 as additional cost of the property.

A few examples of personal taxes paid which are either deductible or not deductible on Page 3 of Form 1040:

Deductible

Taxes for which taxpayer is personally liable.

Taxes paid on cooperative apartment.

Husband paying tax on property owned solely by wife if joint return is filed.

Taxes paid by tenant, but landlord must include amount of tax as rental income.

Back taxes by person upon whom they became a lien, when paid.

Personal residence.

Summer residence.

R. I. Cash Sickness (1%).

R. I. Sales tax (2%). May be estimated if reasonable.

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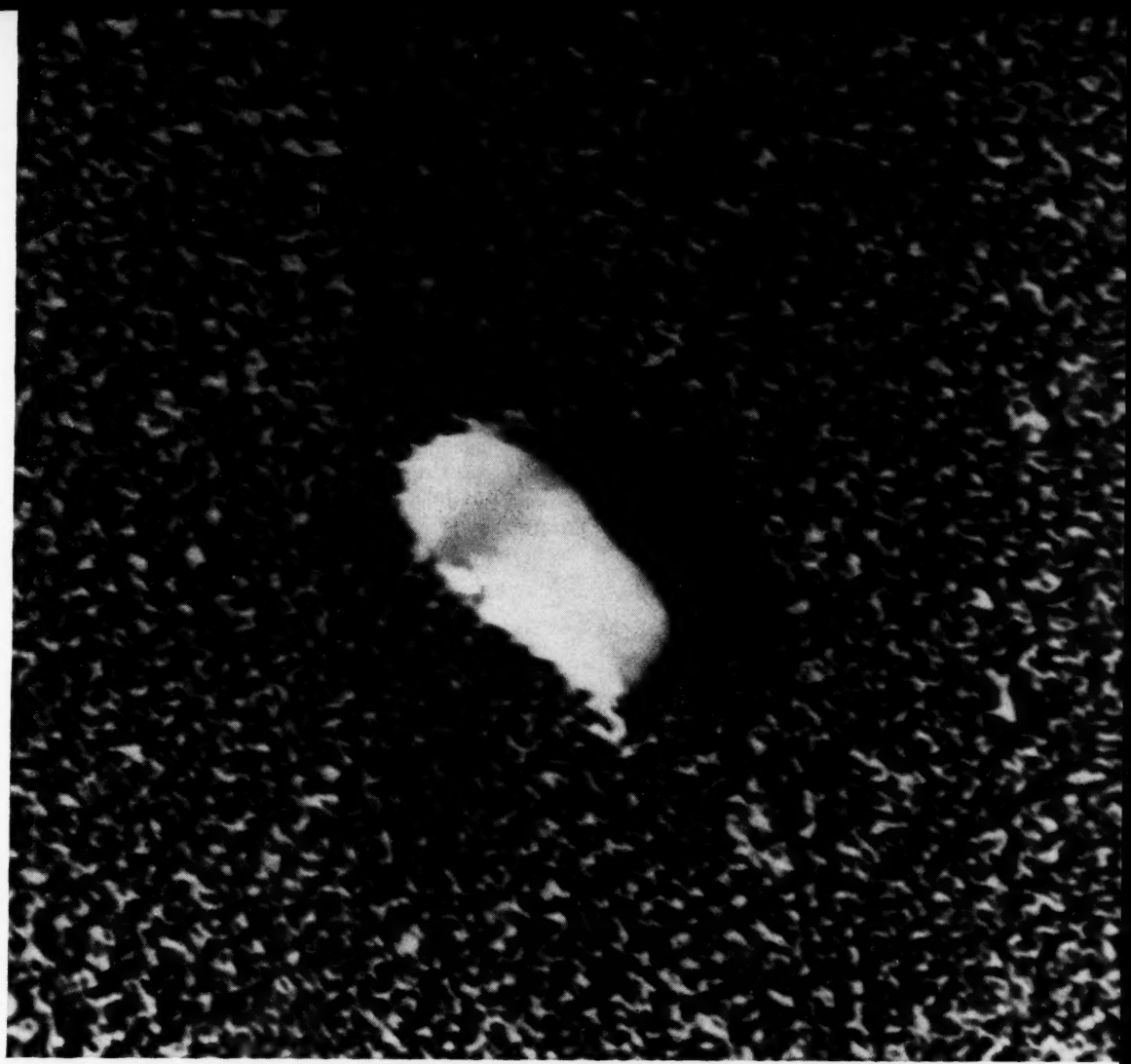

ELECTRON PHOTOMICROGRAPH

Klebsiella pneumoniae 39,000 X

Klebsiella pneumoniae (Friedländer's bacillus) is a Gram-negative, capsulated organism commonly involved in various pathologic conditions of the nose and accessory sinuses, in addition to bronchopneumonia and bronchiectasis.

It is another of the more than 30 organisms susceptible to

PANMYCIN*

100 mg. and 250 mg. capsules

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.

THE DOCTOR AND HIS INCOME TAX

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R. I. gasoline tax (4% gal.) may be estimated if reasonable.

Registration of automobile.

License to drive automobile.

Not deductible

Son paying taxes on property owned by parent (gift).

Assessments for local benefits (street, sidewalk or curb paving).

Husband paying tax on property solely owned by wife if separate returns are filed.

Stockholder who pays tax for corporation. Amount may be treated as additional investment or loans.

Federal jewelry tax.

Federal cosmetic tax.

Federal admission tax.

R. I. liquor tax.

Federal luggage tax.

Federal fur tax.

Federal income tax.

R. I. cigarette tax.

Employees' railroad retirement tax.

Fishing, hunting, dog licenses.

Insurance premiums paid under compulsory automobile insurance laws of a state.

Medical Expense

Under the old code a taxpayer under 65 years of age was limited in his medical expense deduction to the excess of 5% of adjusted gross income. The 5% limitation did not apply with respect to those taxpayers who have attained age 65 or more during the taxable year.

The new code has made two changes with respect to the medical deduction in that the 5% limitation has been reduced to 3% for those taxpayers under 65; it also provides that all taxpayers regardless of age must reduce expenditures for medicines, drugs, prescriptions, etc., by 1% of adjusted gross income, as follows:

Mr. William Bowers, age 63, during 1954 had adjusted gross income of $8,000.00. During the year he expended $175.00 for drugs, medicines and prescriptions, $200.00 for doctors' services and $400.00 for hospital services.

Adjusted gross income			$8,000.00
Medicine and drugs	$175.00		
1% of adjusted gross	80.00		
Balance		$ 95.00	
Doctors' services		200.00	
Hospital services		400.00	
Total		$695.00	
3% of adjusted gross ($8000.00)		240.00	
Medical expense deduction		$455.00	

If Mr. Bowers was 65 years of age in 1954, he would be entitled to the full $695.00 as a medical expense deduction since the 3% limitation would not apply.

The new code has also increased the maximum medical expense allowable as deduction in any year from $1,250.00 (old code) to $2,500.00 for each exemption on the return not including the added exemption allowable to those taxpayers who are blind or 65 years of age or more as follows:

Status	*No. of exemptions on return*	*Maximum allowable*
Single	2	$ 5,000.00
Married (separate return)	2	5,000.00
Married (joint return)	4	10,000.00
Head of household	4	10,000.00
Surviving spouse	4	10,000.00

The new law has corrected an inequity to those taxpayers who incurred medical expense, died during the year, and had not paid the expense up to date of death. Under the old law the expense so paid by the estate of the decedent was not deductible but under the new code it is, provided that if the estate pays the decedent's medical expense within one year after his death, the amount so paid will be treated as having been paid by the decedent and deductible if it qualifies on the last return filed for him as follows:

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THE DOCTOR AND HIS INCOME TAX

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In 1954, Mr. William Doe incurred a medical bill of $600.00, which he did not pay up to date of his death June 1, 1954. It was paid by his executor on Nov. 10, 1954. The executor may deduct the medical expense deduction on Mr. Doe's individual return for 1954. The deduction applies only with respect to Mr. Doe's unpaid medical, any bills incurred by his dependents would not be allowed.

Medical expenses are deductible in the year paid and not in the year incurred, therefore if an individual's present wife incurred a medical bill when she was single the husband would be permitted to deduct the bill in the years paid, because she was his wife when paid. The same will hold true with respect to a son who was a dependent in 1951 when the bill was incurred but is not a dependent in 1954, when the parent pays the bill. If the son was not a dependent when the bill was incurred and is a dependent in the year it is paid the parent or person who furnished over one-half his support would be permitted the medical expense deduction.

An individual may be a dependent for medical expense purposes and not for exemption purposes as follows:

Dr. William Beane during 1954 paid medical and hospital bills of $2,300.00 for his mother who did not live with him, and during 1954 Dr. Beane's mother had income from dividends of $2,000.00. Although Dr. Beane may not claim a dependency deduction of $600.00 for his mother as she had $600.00 or more of gross income during the year, he would be allowed to deduct the medical expense he paid of $2,300.00, if it qualified, for his mother since he furnished over one-half her support during the year.

Recoveries of medical expense in current years which was deducted during prior years is treated as follows:

Taxpayer	*Medical expense taken previous year*	*Received in 1954*	*Taxable in 1954*
A	200	$100.00	$100.00
B	100	100.00	100.00
C	20	250.00	20.00

Where a taxpayer used standard deduction in previous year, any reimbursement for medical expense he receives in current year would not be taxed.

Dividend received exclusion

The new code has provided an entirely new concept in the field of federal taxation in that each

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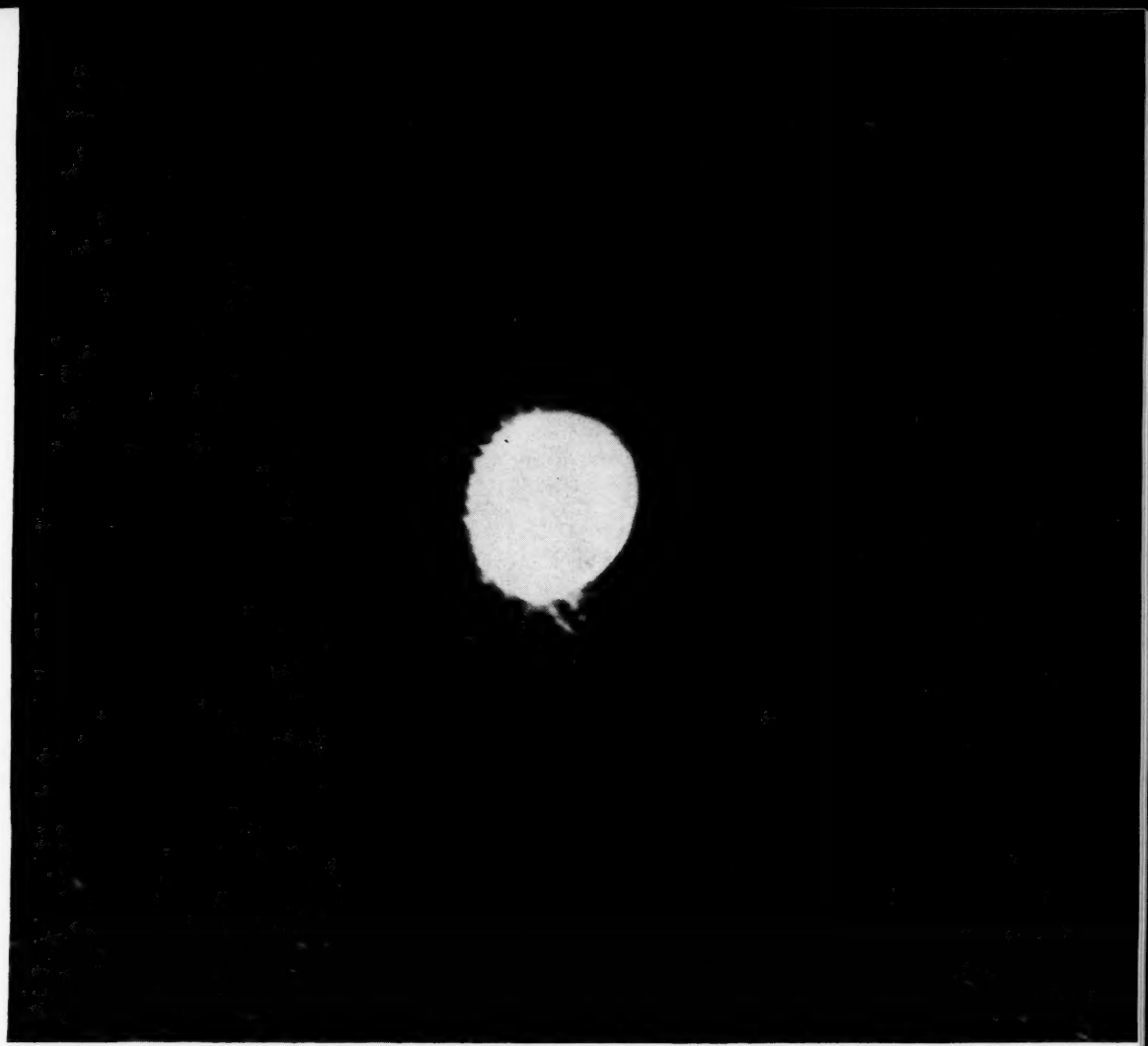

ELECTRON PHOTOMICROGRAPH

Staphylococcus aureus 44,000 X

Staphylococcus aureus (Micrococcus pyogenes var. aureus) is a Gram-positive organism commonly involved in a great variety of pathologic conditions, including

pyoderma • abscesses • empyema • otitis • sinusitis • septicemia

bronchopneumonia • bronchiectasis • tracheobronchitis • and food poisoning.

It is another of the more than 30 organisms susceptible to

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DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

At the annual meeting of the Kent County Medical Society held on December 8, 1954, the following officers were elected to serve for 1955:

President: Briand N. Beaudin, M.D.
Vice President: Peter C. Koch, Jr., M.D.
Secretary: Paul G. Haltenberger, M.D.
Treasurer: John A. Mack, M.D.
Delegates: Peter C. Erinakes, M.D., Edmund J. Hackman, M.D., Russell P. Hager, M.D.
Councillor: Arthur E. Hardy, M.D.
Alternate Councillor: Joseph C. Kent, M.D.

NEWPORT COUNTY MEDICAL SOCIETY

The last meeting of the Newport County Medical Society was called to order by Dr. Robert Bestoso, President, at 7:30 P.M. on December 1, 1954, at the Hotel Viking with twenty-five members attending.

The speaker of the evening was Mr. John Howard Benson, nationally known sculptor and authority on calligraphy. He gave the society a most erudite and instructive conference on the origin of the Old Stone Mill in Newport, accompanied by a series of slides explaining the various architectural and engineering features that entered into the construction of the mill.

The minutes of the last meeting on September 22d were read and approved.

COMMUNICATIONS: A letter from Capt. Enyart, Commanding Officer at the Naval Hospital, was read, expressing his appreciation for the collaboration of the physicians in the County during the *Bennington* disaster.

A letter was read also from the Newport Hospital Student Nurses, announcing their forthcoming Christmas formal dance. All doctors were urged to attend.

COMMITTEE REPORTS: Dr. Brownell, delegate to the State Society, reported on the Conclusions of that Society at their last meeting:

1) That all dues would be rated at $50.00 per annum.
2) That the problem of liability insurance obtained through the State Medical Society is approaching a solution.
3) That all doctors answer questionnaires sent out by the 1st Naval Headquarters regarding their attitude in the matter of civilian doctors being contracted to work on the Naval Base rendering service to civilian employees.

Dr. Zamil reported on the Diabetes Detection Drive, urging all members to fill out the cards, indicating the number of urines checked, and the cases of diabetes discovered. He mentioned that the first Diabetic Fair was a complete success, and requested that all positive patients be re-evaluated as positive diabetes and reported to the local committee for their completed survey report.

NEW BUSINESS: Dr. Adelson made a motion that the secretary of the society address a letter to the Representative Council expressing the society's displeasure concerning the popular statement that "It's easy to get a medical statement from any doctor in Newport." This motion was seconded and passed by the members of the society.

A second motion was made by Dr. Adelson that a letter be sent to Dr. Jerech expressing the regrets of the various members of the society concerning her impending departure. This was seconded by Dr. Ceppi and passed.

The meeting adjourned at 10:00 P.M.

Respectfully submitted,
JOSE M. RAMOS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 1, 1954. The meeting was called to order by the president, Dr. William J. O'Connell, at 8:30 P.M.

Minutes of Previous Meeting

The reading of the minutes of the previous meeting was omitted with the approval of the membership present in view of the fact that the complete minutes are to be published in the RHODE ISLAND MEDICAL JOURNAL.

Report of the Secretary

Dr. Michael DiMaio, secretary, reported that all members of the association had been cordially invited to attend the John F. Kenney Clinic Day

meeting at the Pawtucket Memorial Hospital on Wednesday, November 3, 1954.

Award of Membership Certificates

The president awarded certificates of membership to the physicians elected at the October meeting of the association.

Presentation of Arnar-Stone Laboratories Representative

Mr. L. C. Phinney, of the Arnar-Stone Laboratories, Inc. of Evanston, Illinois, who had a technical exhibit at the meeting, was introduced by Dr. O'Connell to the membership. Mr. Phinney spoke briefly regarding the pharmaceuticals available through his company.

Scientific Program

The president introduced as the speaker of the evening Dr. Wyland F. Leadbetter, chief of Urology at the Massachusetts General Hospital in Boston, Massachusetts, who spoke on the subject of "Office Urology."

Dr. Leadbetter presented in a very enlightening manner many of the urological problems that are encountered in office practice. Tortion of the testicles, he stated, is always to be considered a real emergency. However, this condition is rarely seen early enough to save the involved testicle. The sudden onset of pain in the testicle and prostration are the usual complaints and he recommended operation as soon as possible. Dr. Leadbetter feels that occasionally bilateral operation is indicated in order to prevent the same condition in the opposite testicle.

One of the important congenital defects encountered is hypospadia. He recommends early correction (before school age) and the results are usually satisfactory. Another defect which he mentioned is undescended testicle. This condition may be associated with an inguinal hernia and a fairly good percentage of these patients develop tumors of the testicle later in life. The treatment of this condition varies considerably because of the conflicting literature. He indicated that if there is bilateral undescended testicle, the pituitary gonadotropin may be worthwhile treatment. Where there is one normal and one undescended testicle, Dr. Leadbetter seems to think that early operation brings about the best results. This latter condition is not the result of hormonal deficiency.

The several scrotal lesions that he mentioned are varicocele, hydrocele, spermatocele, and epididymitis. A varicocele is easily identified. A hydrocele on the other hand may be less readily diagnosed, although transillumination aids in the diagnosis. Oftentimes this condition needs to be investigated to rule out an underlying tumor. Epididymitis may be acute or chronic or tuberculous in nature. In tuberculosis, there is an occasional draining sinus.

continued on next page

Urethral inflammatory conditions are gonorrheal urethritis and pyogenic urethritis. Culture and smear, as well as a good history help in the diagnosis. The speaker's observations confirm our own in that there are considerably fewer cases seen at the present time than prior to the advent of the sulfonamides and antibiotics. Staphylococcal infections are the most common cause of nonspecific urethritis and, usually, this is secondary to an infection of the prostate or seminal vessels. Viral urethritis is another problem in which a purulent urethral discharge is noted but the smear is negative. This condition may be associated with Reiters Syndrome. Treatment of viral urethritis is not completely satisfactory. Neoarsphenimine is used and so are some of the broad spectrum antibiotics. Prostatitis and urethritis are usually associated with some urinary pain and urethral discharge in the morning. Prostatic massage and an examination of the secretions are helpful in the diagnosis. The antibiotics are not helpful in these conditions unless the prostate drains freely. The purpose of prostatic massage is to provide drainage and to unblock blocked ducts. Dr. Leadbetter recommends using antibiotics and massage one time per week in these conditions, until the prostate gland feels reasonably normal and is draining normally. Proper drainage eliminates the clumping of the pus cells when the discharge is examined microscopically. The speaker indicated that prostatitis may come from a secondary focus such as teeth, tonsils, etc.

It was the speaker's feeling that a child with any kind of urinary trouble should have an intravenous pyelogram. This also applies to anyone having hematuria. A complete urological workup is often necessary to rule out multiple lesions of the genitourinary tract. In speaking about carcinoma of the prostate, Dr. Leadbetter pointed out that many patients over fifty years of age that have a prostate which does not feel right should be seen by a urologist. Twenty per cent of males over fifty years of age will develop carcinoma of the prostate. In this condition, over fifty per cent of the patients have a five-year survival, thirty per cent a ten-year survival.

Dr. Leadbetter's talk was well received.

The meeting adjourned at 9:50 P.M.

Attendance was 87.

Collation was served.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, December 6, 1954. The meeting was

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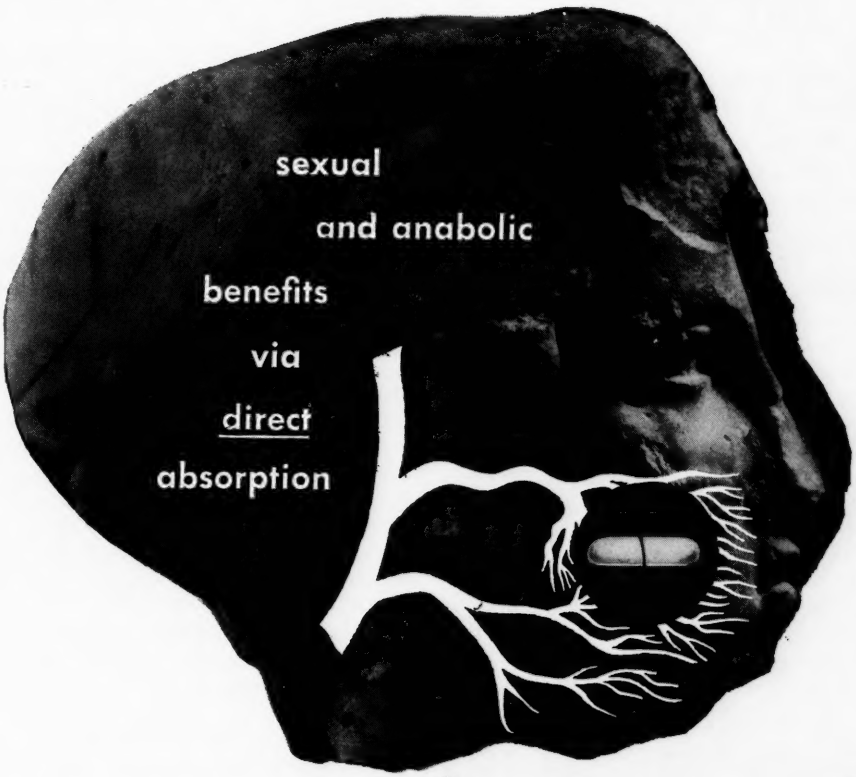

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PROVIDENCE MEDICAL ASSOCIATION

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called to order by the president, Dr. William J. O'Connell, at 8:30 P.M. Due to inclement weather the attendance at the meeting was far less than usual.

Minutes of Previous Meeting

The minutes of the previous meeting were approved and were not read since it was announced that they would be published in the RHODE ISLAND MEDICAL JOURNAL.

Report of Executive Committee

The secretary, Dr. Michael DiMaio, reported that the Executive Committee had taken the following actions:

1. In accordance with the By-Laws it prepared and submitted by mail to the membership a slate of officers to serve in 1955, and to be voted upon at the annual meeting on January 3, 1955. Counter nominations to this slate must be in writing, signed by ten members of the association, and submitted to the secretary at least ten days prior to the annual meeting.

2. The committee authorized the president to appoint a By-Laws Review Committee to meet with the legal counsel of the Rhode Island Medical Society to study and review the matter of membership requirements of the association, and to submit a report to the Executive Committee on its findings at a subsequent date.

3. The committee voted that a citation be prepared in proper form for presentation to the city's two rescue squads at the annual meeting on January 3, 1955.

It was moved that the report be approved and placed on file. The motion was seconded and adopted.

Announcement by the President

The president announced that the committee consisting of Drs. James H. Fagan and Angelo Archetto had submitted the association's tribute to the late Dr. Frank E. McEvoy.

Election of New Members

The secretary reported that the Executive Committee recommends for election to active membership the following physicians: Ivan Basilevich, M.D., State Hospital for Mental Diseases, Howard, Rhode Island, and Charles Joseph Hutchinson, M.D., Andrews House, Brown University, Providence, Rhode Island.

It was moved that both nominees be elected as active members of the association. The motion was seconded and adopted.

Scientific Program

The president introduced Dr. Magnus I. Smedal, Chief of Radiological Service at the Lahey Clinic and the New England Baptist Hospital, and Research Associate at the Massachusetts Institute of Technology, who spoke on "Observations on Supervoltage X-Ray Therapy and Cathode Ray Therapy."

Dr. Smedal reviewed the use of high voltage X ray in the treatment of medical problems. He presented this very difficult subject in a very pleasing and understandable manner.

In selected ambulatory patients, the Massachusetts Institute of Technology's three million volt x-ray machine is used. The speaker presented all the advantages and disadvantages of x-ray radiation therapy. He was particularly emphatic about the advantages of rotational x-ray therapy. His excellent lecture was supplemented by the use of lantern slides.

An interesting discussion period followed the presentation.

The meeting adjourned at 10:05 P.M.

Attendance was 39.

Collation was served.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

WOONSOCKET DISTRICT SOCIETY

A meeting held in the Woonsocket Hospital auditorium was called to order by President Joseph McKenna at 8:50 P.M., on December 14, 1954. Dr. Alton Thomas was appointed acting secretary. The minutes of the last meeting were read and approved.

The application of Ernest L. Dupre, M.D. for membership in the Woonsocket District Society was read and is to be processed acording to the society's by-laws.

Messages of appreciation for flowers sent by the society were read from Dr. Edgar Tanguay, who recently lost his wife, and from Mrs. Sylvio Remy. Dr. Remy died in October, 1954.

Dr. McKenna informed the society that Commissioner of Public Safety for the city of Woonsocket, Gustave LaBreche, had requested assistance from the society in selecting the proper equipment for the emergency bag carried by the police ambulance and by the Woonsocket Fire Department rescue vehicle. On a motion made by Dr. Francis King and seconded by Dr. Morrison, the president appointed a committee of two to act as advisers on this matter. (Dr. Gerald Lamoureux, chairman, and Dr. Harry Levine.)

A nominating committee for officers for the coming year was appointed by the president and consisted of Drs. Francis King, Joseph Bliss and Carlo DeStefani. They returned the following slate:

President—Dr. Saul A. Wittes
Vice President—Dr. Francis Vose
Secretary—Dr. Alton Thomas
Treasurer—Dr. Paul Boucher
Censors—Drs. Joseph Reilly, Francis King and Victor Monti
Councillor—Dr. Joseph McKenna
Delegates—Drs. Francis Vose and Alfred King.

Dr. Francis Vose nominated from the floor Dr. Joseph Bliss for the office of Vice President. Seconded by Dr. Leo Dugas. A written ballot was taken and Dr. Vose was elected vice president. As no other counter nominations were proposed, the president instructed the secretary to cast one vote for the above slate of officers, and they were duly elected.

Dr. McKenna turned over the gavel to the new president, Dr. Saul Wittes, at 9:30 P.M. As there was no further business, the meeting was adjourned at 9:32 P.M.

Attendance was 20 members.

No refreshments were served.

Respectfully submitted,
ALTON P. THOMAS, M.D., *Secretary*

THE DOCTOR AND HIS INCOME TAX

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taxpayer may exclude the first $50.00 of taxable dividends received in 1954 from domestic corporations. The exclusion applies to all taxpayers whose taxable year ends after July 31, 1954.

Where a husband and wife file a joint return, the $50.00 exclusion is permitted to both provided that each spouse has divided income of $50.00 or more in their own right. If only one spouse had dividend income then the $50.00 exclusion would apply only to the spouse who received the dividends irrespective of whether separate or joint return is filed. Examples:

(1) Dr. Henry Scholl during 1954 received taxable dividends from domestic corporations in the amount of $760.00, and his wife May received $250.00 on securities owned by her, Dr. Scholl would report $710.00 (760.00 − 50.00) and Mrs. Scholl $200.00 (250.00 − 50.00) on their respective returns if they filed separately and $910.00 if they filed jointly.

(2) Assume in (1) above that Dr. Scholl owned all the securities. Dr. Scholl would only be allowed an exclusion of $50.00 and report in his return $960.00 ($1,010.00 less $50.00) whether he filed separately or jointly.

Dividend received credit

In addition to the exclusion of the first $50.00 of dividends each taxpayer is permitted a 4% tax credit on all dividends received *after July 31, 1954.*

The credit applies to all taxable dividends included in gross income which is not a further exclusion but a cash credit against the tax due on the return. The credit cannot in any case exceed the tax due as the law specifically provides no refund if tax due is less than credit.

The credit is limited the lesser of (a) 4% of the dividends received after July 31, 1954, (b) Tax shown on return or (c) 2% of taxable income (line 5 page 3).

(1) Dr. Mark Abbott during 1954 received $8,000.00 as dividends from the Acme Corporation, $2,000.00 each on Jan. 15, April 15, July 15, and Oct. 15 respectively. Dr. Abbott had taxable income of $6,000.00. He was married, had no dependent, filed a joint return and his tax for the year was $760.00. On his return he reported dividends of $7,950.00 (8,000.00 − 50.00 exclusion) and his credit would be $80.00 the lesser of the following:

4% of dividends of $2,000.00 after July 31, 1954	$ 80.00
tax due on return	760.00
2% of taxable income of $6,000.00	120.00

(2) Assume in the above example that the dividends were paid semi-annually in the amount of $4,000.00 on Feb. 15 and $4,000.00 on Aug. 15, 1954, the allowable dividend credit would be $120.00, the lesser of the following:

4% of $4,000.00 received after July 31, 1954	$160.00
tax due on return before credit	760.00
2% of taxable income of $6,000.00	120.00

The credit would be computed in the same manner whether a joint or a separate return was filed by Dr. Abbott and Mrs. Abbott.

Retirement income credit

This is an entirely new concept regarding credits against tax and for many individuals will result in a tax saving for 1954. In order to qualify, a taxpayer must have earned income of $600.00 or more for any ten years preceding the taxable year. It is necessary to determine the retirement income which may not in any case exceed $1200.00 for each taxpayer which is applicable to both husband and wife if a joint return is filed. The credit against tax may not be in excess of $240.00 (20% of $1200.00), and in no case may it exceed the tax due before the credit is applied.

Retirement income includes for those taxpayers who

(1) *Have attained age 65 before the close of the taxable year:* Pensions, annuities, dividends, interest and gross rental income.

(2) *Have not attained age 65 before the close of the taxable year:* Pensions and annuities from a public retirement system such as pensions and annuities received from United States (military excepted), states, cities, towns, District of Columbia, or territories and possessions of U. S.

The retirement income so computed (not in excess of $1200.00) must be reduced by the receipt of any of the following whether the taxpayer is over 65 or not:

(1) Social security pensions

(2) Railroad retirement pensions

(3) Any income earned during the year in excess of $900.00. If the taxpayer is seventy-five years or more by the close of the year, no reduction is necessary where there is earned income in excess of $900.00.

Earned income is construed as wages, salaries, commissions, profits of professional practitioners; the net profit from business where income is derived by investment of capital and services is multiplied by 30% to determine the earned income.

Examples:

(1) Dr. William Heath, age 65, during 1954 had taxable dividend income of $8,000.00 and gross rents of $9,000.00 (net profit of $3,100.00). During his years of practice, Dr. Heath was employed as a visiting physician (employee) by the A.B.C. Corporation, for which he received a Social Security pension of $385.00. He earned as consultant $1,300.00 during the year. Dr. Heath would compute his retirement credit as follows:

Retirement Income		
Dividends	$8,000.00	
Interest	3,000.00	
Gross rents	9,000.00	
Total		$20,000.00
Maximum applicable		1,200.00
Less:		
S. S. Pension	$385.00	
Consultant fees $1,300 less $900.00	400.00	
Total		785.00
Subject to credit of 20%		$415.00
Credit allowable against tax		83.00

(2) Assume in (1) above the facts were the same except that Dr. Heath was 75 years of age in 1954.

Maximum retirement income	$1,200.00
Less Social Security Pension	385.00
Subject to credit of 20%	$815.00
Credit allowable against tax	$163.00

(3) Assume in (2) above that Dr. Heath's tax due for 1954 was (before application of credit) $143.00. He would pay no tax but would not be entitled to a refund of $20.00 as there is no refund where the credit exceeds the tax due for the year.

A surviving spouse who had no earned income of $600.00 or more for any of the ten years preceding the current year would qualify if her decedent spouse would have qualified if he or she had lived. Thus—

Mrs. Mary Johnson, widow of Dr. Henry Johnson, did not have earned income of $600.00 or more during any of the preceding ten years. If Dr. Johnson had lived in 1954, he would have qualified and because of this Mrs. Johnson would qualify for the tax credit, if any, because she is the survivor of the taxpayer who would have qualified if he had lived. Of course if Dr. Johnson had lived he would be entitled to the credit, if any, but Mrs. Johnson would not qualify for the credit.

To be continued in the February issue.

INDEX TO ADVERTISERS

THROUGH . . . the Microscope

Physicians Slated for Military Service

To meet the Defense Department call for 1,275 physicians for induction next March, draft boards have started processing men through the age thirty-seven. Selective Service headquarters instructed boards to call up for examination those priority III physicians born on or after January 1, 1917, where previously the cutoff birth date was August 30, 1922. Priority I of all ages and Priority II men without restriction as to months of service also are being used for the March call. A total of 300 interns have been selected by the Defense Department for deferment for one year residencies in fifteen medical specialties essential to the military departments. The names were drawn by lot from among more than 1,300 non-veteran interns who asked for further deferment.

Polio in Rhode Island in 1954

The National Foundation for Infantile Paralysis has reported that the polio attack rate in Rhode Island in the year just ended was about 37 per cent lower than the national average, according to provisional reports. Nationwide, the number of cases reported in 1954 was the third highest on record.

Yet in 1953, when 295 polio cases were reported, the attack rate in Rhode Island was 59 per cent higher than the national average. It is impossible to predict where and when polio epidemics will strike, which underlines the need for more effective control measures.

Evaluation of the Salk vaccine, administered to 440,000 U. S. children, in the largest medical experiment of its kind ever conducted, is now in progress. Announcement of the vaccine's effectiveness will be made in the spring of 1955.

During the field trials last spring about 3,500 children in the state of Rhode Island were inoculated with the Salk vaccine.

Federal Government Medical Services

The 80 medical schools in the United States will operate on a budget of approximately $93,408,312 during the fiscal year 1954-1955.

To operate the federal government medical, health, and related activities during the fiscal year 1954-1955, approximately 25 times as much money is required, or approximately $2,141,681,661. This represents one-sixth of the total United States health bill (12 billion dollars), as estimated by the Department of Commerce.

Some 25 federal agencies and departments are involved in this federal government medical program. The Panama Canal Zone with a "fee for service based on the individual's income bracket," represents one type of program, while the State Department's interest in the World Health Organization's health program in some 69 foreign countries is still another type.

The several thousand physicians involved in this federal government medical program include a limited number of "drafted physicians" in the Armed Forces, as well as many volunteers and career men in each of the 25 federal agencies and departments.

Size and cost are criteria for measurement in many instances but a federal government medical service needs to be evaluated as to "policy and ideology"—only well-informed citizens can make such evaluation in a democratic form of government.

The Press Comments on VA Medical Care

The following excerpts from editorial comments on the AMA policy or the VA problem itself are evidence that this question is being considered outside the medical profession itself:

The Indianapolis News, August 21, 1954:

> A welfare-state philosophy which holds that the government, and not the individual, should pay for medical care has established firm roots at U.S. Veterans Administration hospitals here and throughout the country.
>
> These hospitals give free medical care for non-service-connected ailments in spite of the fact that the patients may be wealthy and well able to pay. All the patient has to do is sign a pauper's oath and there is little or no further investigation.

continued on page 54

THROUGH THE MICROSCOPE

continued from page 52

Uncle Sam—and that means the taxpayers—foots the bill. . . .

There is no quarrel with free medical care for veterans whose ailments or disabilities arose from service to their country. . . . But there certainly is a quarrel with a system which gives free handouts to a man who is able to pay just because at one time in his life he served in uniform. . . .

The Boston Herald, September 3, 1954.

Veterans are no longer a special minority class of men who made an extraordinary sacrifice. They are the majority, of the younger generation, at least, who were drafted and served like almost everyone else.

Those who were hurt in battle—or even hurt far from battle—deserve special medical care. But to provide lifetime free care for all veterans is ridiculous.

. . . The AMA deserves attention on this unpopular but important issue.

The Dallas Morning News, September 3, 1954.

The AMA thinks it (tax-supported medical care) should be restricted to those veterans whose disabilities were suffered during their service.

The AMA, it seems to *The News,* is more realistic on the issue (than its opponents). The taxpayer can't extend free medical and hospital care to every veteran's complaint, even to pulling out teeth that rotted eight or nine years after the war ended.

The Des Moines Register, September 2, 1954.

The Register believes that the position of the medical groups is sound; that it is in the interest of the nation on the whole, including veterans, to limit the admission of service-connected cases to veterans hospitals. But even if we disagreed with the medical groups on this question, we would still think they should take a stand on an issue of this kind which involves medical problems. We doubt that any good will is sacrificed by advocating what you believe in. We think it's a good way to gain respect, even from those who disagree with you.

New Orleans States, September 7, 1954.

There is evidence that a considerable section of public opinion backs the medical association position that the veteran able to pay should not get treatment at the taxpayer's expense for his illness and disabilities that are in no way connected with his military service. To us that seems a very reasonable proposition. The (veterans' organization) would be well advised, we think, to endorse this policy. It might result later in better care of the veterans really in need and in the care of their needy dependents. After a while there may not be enough tax money to keep up unlimited treatment for all veterans.

The Danville (Ill.) Commercial-News, September 7, 1954.

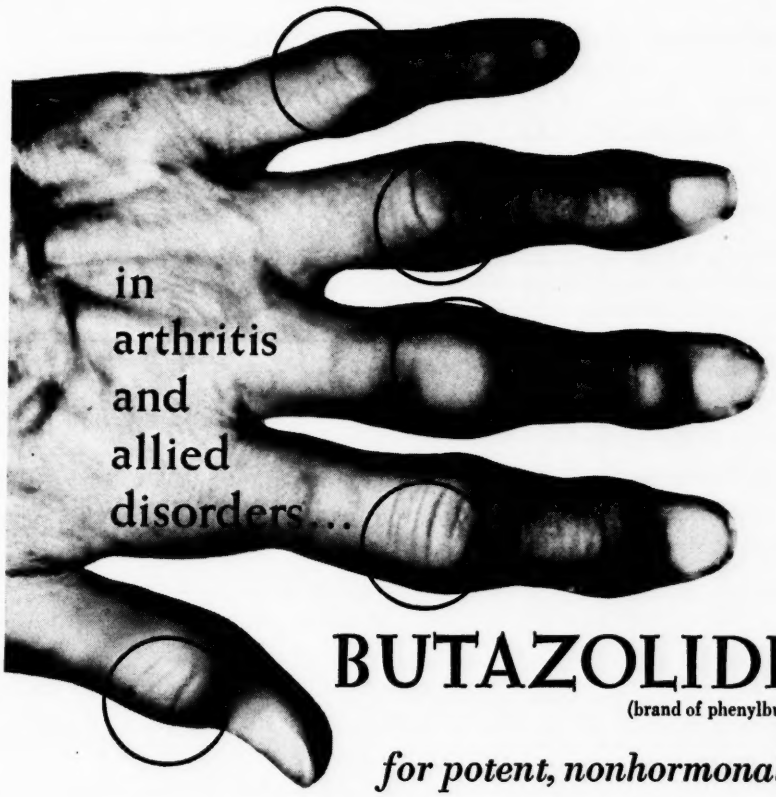
Certainly, every veteran with service-connected illness or injury should receive the best medical care available without expense to himself. This is the least the nation can do for him, and Americans never have tried to shirk this obligation; but unless the rapidly growing program of the Veterans Administration is checked, the American people will be obliged to substitute socialized medicine for their present medical system.

Your AMA Directory Information Card

The new, 19th Edition of the AMERICAN MEDICAL DIRECTORY is now in galley form, and it is expected that the book will be ready for delivery about the middle of 1955. The previous edition was issued in 1950. Since that time, it has not been possible to publish a new edition because changes in the membership structure of the American Medical Association made it difficult to obtain an accurate list of members.

Within the next few weeks, a directory information card will have been mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new directory. Physicians receiving an information card should fill it out and return it promptly regardless of whether any change has occurred in any of the points on which information is requested. It is urged that physicians also fill out the right half of the card, which section requests information to be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, he should mail the card promptly to the Directory Department of the American Medical Association to insure an accurate listing of his name and address. There is no charge for publishing the data, nor are physicians obligated in any way.

The directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations, and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and statistics on the distribution of physicians and hospitals in the United States.



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Detailed literature on request.

*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: Geriatrics 9:111 (Mar.) 1954.

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PROGRAM FOR THE SECTIONAL MEETING

of the

AMERICAN COLLEGE OF SURGEONS

Sheraton-Biltmore Hotel, Providence, Rhode Island

March 3, 4, 5, 1955

All Members of the Rhode Island Medical Society are invited to attend the Meeting

Registration Fee $5.00, except for members of the College, residents and interns

THURSDAY, MARCH 3

8:00 a.m. REGISTRATION

8:30-12:00 noon SCIENTIFIC SESSIONS

8:30-10:30 a.m. Henri E. Gauthier, M.D., F.A.C.S., *Chairman, Committee on Arrangements,* Presiding

NEPHRECTOMY (Medical Motion Picture) . . Robert M. Janes, M.D., F.A.C.S., *Toronto*

THE ACUTE GALL BLADDER . . . . . Orland F. Smith, M.D., F.A.C.S., *Providence*

GUIDING THE DAILY CARE OF THE SICK SURGICAL PATIENT
Francis D. Moore, M.D., F.A.C.S., *Boston*

THE CLINICAL ROLE OF PLASMA VOLUME EXPANDERS
Jonathan E. Rhoads, M.D., F.A.C.S., *Philadelphia*

10:30-12:00 noon ***Symposium on Trauma,*** Robert T. Henry, M.D., F.A.C.S., *Pawtucket,* Presiding

EMERGENCY TREATMENT OF ARTERIAL INJURIES
Richard Warren, M.D., F.A.C.S., *Brookline*

OPEN WOUNDS OF THE HAND . . . . . J. Edward Flynn, M.D., F.A.C.S., *Boston*

PHYSIOLOGICAL BASIS FOR THE TREATMENT OF THORACIC TRAUMA
John W. Strieder, M.D., F.A.C.S., *Brookline*

12:00-1:30 p.m. ***Luncheon*** and Program for surgeons interested in the Surgery of Trauma

1:30 p.m. THORACO-ABDOMINAL ECTOPIA CORDIS (Medical Motion Picture)
Hugh B. Lynn, M.D., *Louisville*

2:00-5:00 p.m. Lloyd Brown, M.D., F.A.C.S., *Bangor, Maine,* Presiding

2:00-3:25 p.m. ***Symposium on Pediatric Surgery***

THE MANAGEMENT OF ABDOMINAL TUMORS IN CHILDREN
C. Everett Koop, M.D., F.A.C.S., *Philadelphia*

THE DIAGNOSIS AND MANAGEMENT OF INTESTINAL OBSTRUCTION IN INFANTS AND CHILDREN . . . . . Orvar Swenson, M.D., F.A.C.S., *Boston*

CONGENITAL ATRESIA OF THE ESOPHAGUS WITH TRACHEO-ESOPHAGEAL FISTULA . . . . . Jose M. Ferrer, Jr., M.D., F.A.C.S., *New York*

3:35-5:00 p.m. ***Panel Discussion — Acute Renal Failure***

Moderator: Francis D. Moore, M.D., F.A.C.S., *Boston*

Collaborators: John Merrill, M.D., *Boston*
Jacob Fine, M.D., F.A.C.S., *Boston*
Ernest K. Landsteiner, M.D., *Providence*

6:00-6:45 p.m. ***Reception,*** Foyer of Ballroom

6:30 p.m. ***Dinner,*** Ballroom Leland S. McKittrick, M.D., F.A.C.S., *Brookline,* Presiding

THE COLLEGE, AN INSTITUTION, RATHER THAN A SOCIETY
Paul R. Hawley, M.D., The Director

8:30 p.m. ***Medical Motion Pictures***

SURGICAL TREATMENT OF HIATAL HERNIA
Brian Blades, M.D., F.A.C.S., *Washington, D. C.*

HEMIGASTRECTOMY, VAGOTOMY AND GASTRODUODENOSTOMY IN THE TREATMENT OF DUODENAL ULCER, Robert J. Coffey, M.D., F.A.C.S., *Washington, D. C.*

SUBDIAPHRAGMATIC ABSCESS, Howard H. Bradshaw, M.D., F.A.C.S., *Winston-Salem*

FRIDAY, MARCH 4

8:30 a.m. ACUTE ABDOMINAL INJURIES (Medical Motion Picture)
Frederick E. Kredel, M.D., F.A.C.S., *Charleston*

9:30-12:00 noon Clinton R. Mullins, M.D., F.A.C.S., *Concord, N. H.,* Presiding

CONGENITAL ANOMALIES OF THE UROGENITAL TRACT
William J. Engel, M.D., F.A.C.S., *Cleveland*

ESOPHAGEAL HIATUS HERNIA . . . J. Murray Beardsley, M.D., F.A.C.S., *Providence*

ANORECTAL SURGERY . . . . Garnet W. Ault, M.D., F.A.C.S., *Washington, D. C.*

INDICATIONS FOR SPHINCTEROTOMY, Henry Doubilet, M.D., F.A.C.S., *New York*

SOME PERSONAL EXPERIENCES IN THE TREATMENT OF ABDOMINAL ANEURYSM . . . Robert R. Baldridge, M.D., F.A.C.S., *Providence*

FRACTURES OF THE EPIPHYSES . . Alexander P. Aitken, M.D., F.A.C.S., *Brookline*

1:30 p.m. PRECAUTIONS IN RESECTION OF THE COLON FOR CARCINOMA (Medical Motion Picture) . . . . . Warren H. Cole, M.D., F.A.C.S., *Chicago*

2:00-5:00 p.m. George Waterman, M.D., F.A.C.S., *Providence,* Presiding

AN APPRAISAL OF THE EFFICACY OF SURGICAL TREATMENT OF CANCER OF THE ESOPHAGUS . . . . . John H. Garlock, M.D., F.A.C.S., *New York*

SELECTION OF TREATMENT FOR BLADDER TUMORS
William J. Engel, M.D., F.A.C.S., *Cleveland*

ENDOCRINE ASPECTS OF CANCER MANAGEMENT
Danely P. Slaughter, M.D., F.A.C.S., *Chicago*

3:35-5:00 p.m.

THE USE OF THE MECHANICAL HEART-LUNG IN CARDIAC SURGERY
John H. Gibbon, Jr., M.D., F.A.C.S., *Philadelphia*

LARYNGEAL PARESIS AND PARALYSIS, Harold E. Harris, M.D., F.A.C.S., *Cleveland*

DIAGNOSTIC PROBLEMS IN THE CHEST, Julian Johnson, M.D., F.A.C.S., *Philadelphia*

8:30 p.m. ***Surgical Motion Pictures***

COMPLICATED APPENDICITIS . . . . James D. Rives, M.D., F.A.C.S., *New Orleans*

CARCINOMA OF THE THYROID . . . . . Richard B. Cattell, M.D., F.A.C.S., *Boston*

OPERATIONS FOR CORRECTION OF CONGENITAL BILIARY ATRESIA
Robert T. Tidrick, M.D., F.A.C.S., *Iowa City*

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SATURDAY, MARCH 5

9:00 a.m. VOLVULUS OF THE SIGMOID COLON (Medical Motion Picture)
Harwell Wilson, M.D., F.A.C.S., *Memphis*

9:30 a.m.-12:00 noon Wilfred I. Carney, M.D., F.A.C.S., *Providence,* Presiding

SURGICAL DISEASES OF THE SPLEEN, Robert M. Zollinger, M.D., F.A.C.S., *Columbus*

THE GASTRIC ULCER PROBLEM . . . . I. S. Ravdin, M.D., F.A.C.S., *Philadelphia*

SPECIAL PROBLEMS IN PANCREATIC SURGERY
Richard B. Cattell, M.D., F.A.C.S., *Boston*

10:30 a.m.-12:00 noon ***Panel Discussion — Biliary Tract Surgery***

Moderator: I. S. Ravdin, M.D., F.A.C.S., *Philadelphia*

Collaborators: Robert M. Zollinger, M.D., F.A.C.S., *Columbus*
Richard B. Cattell, M.D., F.A.C.S., *Boston*
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BOOK REVIEW

ALL CREATURES HERE BELOW by Joseph Garland, M.D., illustrated by Rene Martin. Houghton Mifflin Company, Boston, Massachusetts. $2.00.

The bookstore proprietor listed this book as suitable for the 9 to 12 year age. It is customary nowadays to tell those who wish to write for a large mass of the general public that they should write for the 14-year-olders, and the suggestion evidently is that they write down to the 14-year-olders. Dr. Garland has most certainly written up for the 9-year-olders. My wife intends to give a copy of this book to her 9-year-old nephew. I think he will enjoy it for he is destined to develop well beyond 14. I am sure that a 69-year-older would enjoy this book.

The clever editor of the NEW ENGLAND JOURNAL OF MEDICINE starts with his memories of the time when the earth was evolving from chaos; soon plant life developed followed by animal life. I see no reason why the spaceship travelers should not be greatly interested by the strange forms of animal life of those ancient days so well described by the author and delightfully illustrated by Rene Martin. Having given us this preliminary view, Dr. Garland then goes back for a running start and describes the different phyla or main groups of animals as they have developed through the eons from the amoeba and other single-celled animals up to the primates which latter includes Genus Homo or homo sapiens whom we are pleased to describe as the ultimate product of development.

I feel certain that all of you will find some most interesting details about these amphibians, reptiles, insects, and birds, to mention a few of these great groups. It is no easy matter to write so as to interest the intelligent 9-year-olds or the, we trust, equally intelligent, 69-year-older, but Dr. Garland has done this. I hope a lot of you look this book over.

PETER PINEO CHASE, M.D.